Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 12:06 PM Philip Louis Silver June 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Olnu Montgomery Montgomery General Hospita 9. Birthplace (State or Foreign Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours New York, NY 1 X M 2 D F 0272871917 132-03-2200 **Director** Usual Residence of Decedent 3a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 X Yes 2 ☐ No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 United States Funeral r than "natural", or items 23a the Medical Examiner must be 3210 North Leisure World Blvd., #1021 death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc 1 Never Married 2 K Married þ Maryland 21215-0036 within 72 hours after White 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Person Manufacturing Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of Laura "Unknown" Harry Silver Baltimore, Maryla permit. Page 1 and 2 should be Department of Health and Meni Important. If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) 3210 North Leisure World Blvd, #1021 Silver Spring, MD Ruth Silver-Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 X Removal from State Falls Church, VA National Crematory 06/25/2010 4 ☐ Donation 5 ☐ Other (Specify) and Address of Facility Edward, Sagel Funeral Direction, Rockville, MD 20852 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Preumonio Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying as the burial-transit Cause (Disease or imjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No detached g 🗌 Unknown P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has death? certificate 1 Yes 2 No To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Nonpatient 2 ER/Outpatient 3 DOA 욘 27 Manner of Death 28a Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Bichhuon 54996

State Registrar Bichhuona

31, Date filed (Month Day, Year)
JUN 24 2010

Prince

18101

62. Registrar's Signature

Philip

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dinh

June

21

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:45 P M Doris Spiritos 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Court <u>Montgomery</u> Bedford <u>Assisted</u> Social Security Number 9. Birthplace (State or Foreign Country) NY 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🏻 F (Month, Day, Year) 09/17/1928 Months Min Yrs. Director 123-20-0009 Usual Residence of Deceden 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 3701<u>Internatinal</u> Dr. 20906 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2K No Specify: Specify: 3 X Widowed 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainmate. College (1-4 or 5+) Elementary/Seconday (0-12) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Mae "unknown" Peter Reiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theatre Circle Olney, MD 20832 2138 Rose Samuel Spiritos / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (S) Judean Memorial Grdns 06/23/2010 Olney, Maryland 21. Signature of Funer 22 Name and Address of Facility Edward Sagel Funeral Direction Inc. Rockville Pike Rockville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) by the attending physician tached for use as the buna Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗓 No 5 Other (specify) Month Year Day Pregnant at time of death signed by the a d be detached f 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown been si should I Completed 24b. Were autopsy findings available 24a. Was an the Hospital or Attending Physician: The law autopsy performed Yes 2 X prior to completion of cause of death? After this certificate has page 2 2 X No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living Hospital 2 X No ဂ္ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: X Natural injury 5 Pending death. hours after death uneral Director: A Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State)

P.O. Records, Division of Vital

State

Medical

29a. Certifie

(Check only o 29b. Sign

ture and tit

31. Date filed (Month, Day, Year)

<u>Joseph Kaplan M.D.</u>

JUN 24 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours a
To the Funeral D

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Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Registrar's Signature

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

1814 Prince Philip Dr. Olney, MD 20832

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

June 22, 2010

29c. License number

D35635

State		1:1: 1	1 D = = 11-	_		17 11	10	21502
Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate c	or Death	1	2. Date of Dea	Reg. Na U	10	21503
Physician/ Medical Della Lee Sansbu	ırry					21, Day 010) Year	3. Time of Death 11:11 Ам
Examiner 4a. Facility Name (if not institution, give street and number) Suburban Hospital		4b. City, Tow	n, or Locatio	n of Death		1	y of Death	rv
	. last birthday)	If Under 1 Y		ler 24 Hrs.	8. Date of Birt	h	9. Birthp	lace (State or Foreign
Director 236-28-3212 1 1 M 2X-XF 86	Yrs.	Months Da	ays Hours	Min.	11/14/	1923	West	Virginia
Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town or Loc	ation			-	e	1	0d. Inside City Limits
10c. County 10c. C	Was	shingto	n, DC					1XXYes 2 ☐ No
	#218	10f. Zip Co	de 20015			10g. Citizen of USA	What Coun	try?
5201 Connecticut Avenue N.W. 11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	J.S. 13. V	Vas Decedent	of Hispanic C	Origin? (Spe	ecify Yes or No-		ce - Americ	an Indian,
Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Never Married	T 7T 7	Yes, specify (Hican, etc.)	Bla Specif	nck, White, e	hite
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21. Signatury of Funeral Service Licensee	22	Name and Ac 160 Ox	ddress of Fac	Geor	ge P. K Oxon H	alas Fu Mill, Ma	neral rylan	Home PA d 20745
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Ph sician/ Medical Immediate Cause (Final disease or condition resulting in death)	SAUPA	4	FIBI	205	5			Onset and Death
Examiner Due to (or as a conse	quence ot):	A						
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28a. Date of injury (Month, Day, Year) 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec.		М	work? 1 Yes 2	□ No				_
4 Homicide determined 28e. Place of Injury - At being a second in the second se	home, farm, stre ify)	et, factory, off	fice		28f. Location (S City or Tow		ber or Rural	Route Number,
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only one) 3 L Certifying Nurse Practioner: To the best of the post of certifier of the best of the post of certifier of the best of the post of the po	my knowledge, o		at the time, di cense numbe			e cause(s) and n 29d. Date sign		
Alliells		D42	2518			June 22		-
30. Name and address of person who completed cause of death (Ite G. Chablani MD 11119 Rockville Pik			20852	<u> </u>	•			
State Registrar 31. Date filed (Month, Day Year) 32. Regist r's Sign					-	•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23^{Day} 2010^{Year} June 8:00 A Ralph Frederick Satterfield Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, in 30, Days Hours Min. 1 🛛 M 2 🗀 Washington, DC Director 579-36-7093 78 Jun Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 X Yes 2 No MD Prince George's Hyattsville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? be ms 23a (must be Funeral USA 2629 Nicholson St., 20782 Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, "natural", or ite Armed Forces?

1 🕱 Yes 2 🗆 No Korean Black White etc. Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Yes. Give 3X Widowed 4 ☐ Divorced Completed War Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Department of h and Mental Hygiene.
7 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frederick Satterfield Dorrence Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2629 Nicholson St. #3, Hyattsville, MD 20782 David R. Satterfield - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State 6/28/2010 Cedar Hill Cemetery Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 4739 Baltimore Ave. 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last and burial-tran attending physician for use as the buria by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 TANo ၉ 1 Tes 1 X Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending after death. Director: Aft Accident Investigation the 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, upleted filled in by determined the Hospital 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 21 31. Date filed (Month, Day, Year)

JUN 2 8 2010 32. Registrer's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 12:00 PM NARNEL SAVOY JUNE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 13100 OLD FLETCHERSTOWN ROAD BOWIE PRINCE GEORGE'S Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours Min 217-42-4201 65 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No MD PRINCE GEORGE'S BOWIE 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 13100 OLD FLETCHERSTOWN ROAD 20721 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH MAIL CARRIER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANK SAVOY IRENE FLETCHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROMAINE BRANDFORD/SISTER 3100 OLD FLETCHERSTOWN ROAD BOWTE. MARYLAND 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 6/24/2010 4 Donation 5 Other (Specify) CLINTON, MARYLAND 21 Signature of Fundal Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final COLON CARCINOMA WITH METASTASIS disease or condition resulting in death) Due to (or as a consequence of):

Physician/ Medical **Examiner**

permit. Page 1 and 2 should be filed wi Department of Health and Mental Hyglic Important: If item 27 is marked other any injury or other traumatic event, #

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

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er than "natural", or items 23a or the Medical Examiner must be 1

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

-	Sequentially list conditions.	b	
xamine	if any heading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a consequence of): Due to (or as a consequence of):	
dical E	resulting in death) Last	d	
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
ted by P	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🏋 No 3 ☐ Probably 4 ☐ Unknown
Comple			24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No
Be	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)
일	1 X Yes 2 □ No		ne 5 🔀 Residence 6 🗆 Other (Specify)
ficate:	27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	(Month, Day, Year) Injury work? M 1 \(\subseteq \text{Yes} \(2 \subseteq \text{No} \)	8d. Describe how injury occurred
Medical Certificate:	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	R. Location (Street and Number or Rural Route Number, City or Town, State)
Medica	(Check 2 Medical Examin	ician: To the best of my knowledge, death occured at the time, date and place, and ner: On the basis of examination and/or investigation, in my opinion, death occurred at the Practioner: To the best of my knowledge, death occurred at the time, date and place	the time, date and place, and due to the cause(s) and manner stated

29c. License number

D45660

14300 GALLANT FOX LANE # 124 BOWIE, MARYLAND 20715

29d. Date signed (Month, Day, Year)

JUNE 21, 2010

Registrar DHMH 17 Rev 7/2009

State

in 24 hour.
in 24 hour.
io the Funeral Dr.
completed filler

29b. Signature and title of certifie

JUN 2 4 2010

DPINDER

Date filed (Month,

of person who completed cause of death (Item 23a) (Type, Print)

SINGH M.D.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 21, 2010 2:06 P M JUNE RICHARD SULLIVAN Α. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S FORT WASHINGTON FORT WASHINGTON HOSPITAL CENTER 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 X M 2 1 F Yrs. 9/18/1940 New York, NY 69 Director 249-66-0570 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f show 1 XYes 2 □ No Director Maryland Prince George's Fort Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20744 United States 12723 Radburn Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ es 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 KMarried Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 1 ∐Yes 2√∏ No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. In Mental Control of the Mental Office of th Elementary/Secondary (0-12) Government Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Sullivan Pauline Terry ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12723 Radburn Place Fort Washington, MD 20744 Pamela B. Sullivan / Wife Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/12/2010 Arlington, VA Arlington National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 23a. Part 1. Eilter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on philine. 5538 Marlboro Pike Forestville, Maryland 20747 Onset and Death Immediate Cause (Final disease or condition Seene **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate 1 ☐ Yes 2 🛣 No 1 ☐Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: folletely filled in by the death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 👺 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer 29c. License number 11741 Wingiam Road Fort WASHINGTON MAY Rome 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

1. TANNER Mn

31. Date filed (Month, Day, Year)

JUN 2 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D2010 Physician/ Pau1 Allan Sealover June 16 10:15 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House Montgomery Hospice Rockville Montgomery 5. Social Security Number . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Hours $J_{AN}^{Month, Day, Year} 1959$ Director 189-52-6539 51 PA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No MD Montgomery Village Montgomery 10f. Zip Code 10g. Citizen of What Country? Funeral 9533 Ash Hollow Road 20886 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian. Armed Forces 1 X Yes 2 L If Yes, Give Completed by 1 Never Married 2 Married ^{2 □} № 1976-1 Yes 2 No Specify: Specify: Caucasian 3 Widowed 4 Divorced 1980 Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Software Engineer High Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Arthur Sealover Shirley Thelma Mardaga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6818 BalmoralCourt, New Market, MD 21774 Richard Ringel / Executor 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 06/18/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Thibadeau Mortuary Service, p.a. 7 Park Avenue, Gaithersburg, MD 20877 M00956 23a. Paryf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. RECTAL disease or condition resulting in death) CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine dany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or se's consequence of): attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death n signed by the a Id be detached fi 1 Yes 2 9 Unknown Yes 2 No 4 L Pregnant a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq HYPERTENSION 2 No 3 Probably 4 🕅 Unknown icate has been sig page 2 should b Completed I 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 5 \square Residence 6 $\stackrel{\bullet}{\underline{M}}$ Other (Specify) 2 🛛 No HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page

Baltimore, Maryland 21215-0036

State Registrar

Medical

DIANNE RUCHERT, CRNP, 6001 31. Date filed (Month, Day, Year)

JUN 23

6 Could not be

determined

4 Homicide

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUNCASTER MILL ROAD, ROCKVILLE, MD

32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year) JUNE 17, 2010

1 🗌 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

			For	State of	of Marylan				and M				21500
			State Registrar	Loot		Cer	tificate o	Death				2010	
	Physicia Medio		Decedent's Name (First, Middle,	Patricia	. V. Sea	ton				2. Date of De Month June		2010 ear	3. Time of Death 1:54р м
	Examin		4a. Facility Name (if not institution,		,		4b. City, Town				4c	. County of Death	i i
	<u></u>		Prince George 5. Social Security Number	e's Hospi		a 4 h inth day	C If Under 1 Ye	heverl		8. Date of Birt	·b		ce George's
	Funeral Director		212-24-1921	1 □ M 2 🗷 F	7. Age (In yrs. Ia 82	Yrs.	Months Day			(Month, Da March	y, Year)	1928	Maryland
	nd now at	L.	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation				-		10d. Inside City Limits
	larylar 3a-fsl ified	ectc		ice George				Hyatt	sville	2			1 ☐ Yes 2 🌠 No
	the M	I Dir	10e. Street and Number		1		10f. Zip Cod				10g. Ci	tizen of What Cou	
	h with ns 23a nust b	Funeral Director	4407 718.	t Avenue				2078					.s.A.
· ^	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ked other than "natural", or items 2be notified at ite event, the Medical Examiner must be notified at		11. Marital Status1 ☐ Never Married 2 ☐ Marr	Armed Fo	edent Ever in U.S prces? 2 🔀 No	5. 13. V	Vas Decedent o Yes, specify Co	f Hispanic O uban, Mexica	rigin? (Spec an, Puerto R	ify Yes or No- lican, etc.)		14. Race - Amer Black, White	
Maryland 21215-0036	ırs afte ıral", LExan	Completed by	3 🗓 Widowed 4 🗆 Divorced	If Yes, Giv Year or D	ve ·	1	Yes 2 🛛	No Specify	y:			Specify:	White
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12	ithin 7 iene. r than the M	Con	Elementary/Seconday (0-12)	College (1	I-4 or 5+)	life. DO	NOT use retire Hom	emaker	ι			Own	Home
פר	filed wall Hyg	Be	17. Father's Name (First, Middle, L.	ast)				18. Mot	her's Name	(First, Middle,	Maiden	,	
ylaı	ould be filed with and Mental Hygier is marked other tumatic event, th	2		Hugo Gol	-	_				. Virgi	•	· · · · · · · · · · · · · · · · · · ·	Obtainable)
ā M	1 and 2 should be if Health and Menitem 27 is marke other traumatic		19a. Informant's Name/Relationsh Patricia T. Sea			1	-					Town, State, Zip 1d 20715	Code)
	f Healitem 2		20a. Method of Disposition	con - baa	20b. Pi	lace of Dispo	sition (Name of			ate MWC		ocation - City or	Town, State
Ë	e + + = 5		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Julia		matory or other p Mem. P	ark	06/26	/2010	Cum	berland,	, Maryland
Baltimore,	permit. Pag Departmen Important: any injury once.		21. Signature of June al Service L	icent ee	M0124								Home, Inc. ng, MD 20904
			23a. Part 1 Enter the disease, or		caused the death	, ,							Approximate Interval Between
-	Pnysician/	8 0	shock, or heart failure. List o Immediate Cause (Final disease or condition	my one cause on ea	hu enxia								Onset and Death
	Medical Examiner		resulting in death)	a. Due to	(o/ s a consequ	90			- 11				
		ier	Sequentially list conditions,	b. Due to	for se a consequ	iones of:	ne pl	eval	de	كحنا		1.	
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or linjury that initiated events	G									
	death certificate be executed the attending physician and ed for use as the burial-transit	al Ex	resulting in death) Last	Due to	(or as a consequ	ence of):							
760	cate b physic	edical		d									
289	certifi anding use as	m/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnar		l Ectopic prean	ancy			- 1	23d. Date of deli	ivery
Box		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		gnant at time of d		Other (specify,					Month	Day Year
P.O.	law requires that the nas been signed by ti e 2 should be detach	y Ph	Part II. Other significant condition	ns contributing to c	death but not resu	ulting in the u	nderlying cause	given in Par	t I.	23e. Did t	obacco	use contribute to	the cause of death?
S,	uires t in sign uld be	ed by								1 🗆	Yes 2	□ No 3 □ Pr	obably 4 🛛 Unknown
202	2 38	Completed								24a. Was auto	DSV	prior to d	opsy findings available completion of cause of
Ψ̈́										perfo	ormed? 2 N	death? o 1 ☐ Yes	2 🗆 No
Ita	sician certifi irector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		=======================================	10	. Place of De Other:				- C - C - C	
o 	g Phy er this ieral d	e: To	27. Manner of Death	28a. Date	Inpatient 2 of injury oth, Day, Year)	28b. Time of injury	28c. In	njury at		ne 5 ∟ Resi 8d. Describe l		Other (Speci y occurred	TY)
on	eath. or: Aft the fur	ficat	1 X Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation			_ M 1	rork?	□No				
Division of Vital Records,	l or Att after d Direct J in by	Certificate:	4 Homicide determ	28e. Place	e of Injury - At hor ing, etc. (Specify)	me, farm, stre)	eet, factory, offic	ce	2	8f. Location (8 City or Tov			al Route Number,
	To the Hospital or Attending Physician: The within 42 hours after death. To the Funeral Director. After this certificate completed filled in by the funeral director, pag	Medical	(Check 2 Medical E	Physician: To the baxaminer: On the bax	sis of examination	and/or invest	igation, in my or	pinion, death	occurred at t	the time, date a	and place	e, and due to the o	cause(s) and manner stated.
	orthe orthe orthe orthe orthe orthe orthe	Me	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner:	To the best of my	knowledge, o	leath occurred a	t the time, da	te and place	e, and due to th	e cause(s) and manner as ate signed (Month	stated.
	Zo		Magunas, 1	40				8912			6/21	1 4	
	•		30. Name and address of person v	who completed cau									
	-0			5- FIA				ve, Ch	everl	y, Mar	ylan	d 20785	
	Sta Registra		31. Date filed (Worth, Day Year) 23 20	110 Sens	Registrar's Signat	park							

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:30 P M Sarah Lockett Smith June 20, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gaithersburg Wilson Health Care Center Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 06/27/1914 1 M 2 K 95 Virginia Director 226-12-8641 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ral", or items 23a or 28a-f shov Examiner must be rediffed at 1 □Yes 2 TXNo Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 301 Russell Avenue #411 20877 United States Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Montgomery County College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be fill leafth and Mental F of Health and Menta item 27 is marked Mary Baptiste John Kennon Lockett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6732 Heatherford Court Derwood, Maryland 20855 Gordon Lockett Smith (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 2010 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD. 20877 23a. rart1. Enter the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, fir it and little. List only one cause on each line. Immediale C use (Final disease or condition Adult lailure to Thrive **Physician** disease or condition resulting in death) Inemoute /Medical Due to (or as a consequence of): Examiner Advanced dementia, Alpermer's if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): anding physician and use as the burial-transit Due to (or as a consequence of) Box 68760. The law requires that the death certificate be Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) ned by the a O. 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy nerforme Anemia 1 ☐ Yes 2 ☐ No 0 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 14 Robert Buschlack M.S. 04115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELL AVENUE H. ROBERT BIRSCHBACH, MO GAITHERS BURG, 31. Date filed (Month, Day, Year) 72. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 23 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 1 - StateMFND#10a-c; 10e, fiperINF, 6-24-10, BW, McGertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 010 Physician/ June 18. 10:34a M Karen Dorothy Stamos Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care Potomac Potomac 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Feb 27, 1942 1 M 2 X Months Hours Min. Glen Cove, NY Director 68 079-34-3514 Usual Residence of Decedent ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If the 2th anakted other than "natural", or items 23a or 28a-f show or if the 2t smarked other than "natural", or items 2a or 28a-f show or if the 72 smarts event, the Medical Examiner must be notified at. 10a. State MD 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Potomac 1 Yes 2 □ No Washington Montgomery 10e, Street and Number 10714 Potomac Tennis Lane 10g. Citizen of What Country? 105 Zin Code Funeral 20016 United States Chase Parkway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Glen Cove Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Roman Howard Melvin Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5719 Chevy Chase Parkway, Washington DC 20016 Suzanne Carter/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dispesition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State June 22,2010 National Crematory Falls Church, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signatur of Funeral Service License 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Metastatic Uterine Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 A N death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 12 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 은 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
Completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tite of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 18,2010 D31319 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lorero S. Albiol, M.D. 8218 Wisconsin Ave Bethesda, MD 20814

State

Registrar

31. Date filed (Month, Day, Year)

JUN 23

2. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paul Anthony Sweeney Jr June 19,2010 2:30am M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chevy Chase Montgomery 3104 Leland St . Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 212-38-3888 1 X M 2 □ F Hours Dec 28, 1940 Washington DC Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho ant: If item 27 is marked of other than "natural", or items 25a or 28a-f sho uny or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Chevy Chase MD Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 20815 USA 3104 Leland St 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces à 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Finance Stock Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Flora Thrasher Paul Anthony Sweeney Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $3104\ Leland\ St,\ Chevy\ Chase, MD\ 20815$ Barbara Z. Sweeney/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important; If it any injury or o 1 🗆 Burial 2 🛱 Cremation 3 🗆 Removal from State permit. Page Department 6/24/2010 Falls Church, VA National Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC Signature of Funeral Service 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onseta an Death Immediate Cause (Final Hepatocellular Carcinoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hepatic Cirrhosis Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ retai dea.
4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 24 No death? within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\overline{X} \) No Other: 4 \square Nursing Home 5 $buildrel \buildrel \buildr$ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JUN 23

Registrar's Signat

Thomas C. Havell, M.D. 4201 Cathedral Ave, N.W. #114W Washington DC 20016

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6104Dc

June 21,2010

Please Type or Print in Black Indelible Ink, Ensure, All Copies Are Legible.

Amend Item 25 per phys. G906 8/4/10 ak

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GEORGE SERKEDAKIS \mathbf{P}^{M} JUNE 2010 4:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10600 Hayes Avenue Silver Spring Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 115-03-9030 1 🕱 M 2 🗆 F Hours Min. Feb. 16, Year) 1915 ^yNew Mexico Director 95 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 10600 Hayes Avenue USA 20902 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: 3 Divorced Completed Year or Dates. WW-II 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 Guard Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Constantine Serkedakis Helen Ekonomou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Fotine Serkedakis/Wife 10600 Hayes Avenue, Silver Spring, Md 20902 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) July 20 2010 1 😾 Burial 2 □ 🍂 remation 3 🗆 Reg Arlington National Other (Specify) Arlington, Virginia . Signature of Juny ral Ser 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Cnset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final DEMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner TRAUMATIC BRAIN DISEASE Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying executed Cause (Disease or linjury for use as the burial-tran signed by the attending physician and that initiated events Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 9 I Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be a DIABETES MELLITUS TYPE II 1 Tes 2 No 3 Probably 4 X Unknown STROKE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No Yes 2 N Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕱 Residence 6 Nother (Specify) Hospital: ၉ 1 Yes 2 XNo ER/Outpatient 3 DOA 1 \square Inpatient 2 \square 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature ar title of certifier 29d. Date signed (Month, Day, Year) 29c. License number JUNE 21, 2010 MD# 034362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688 NICKIE LEPCHA, M.D., filed (Month, Day, Year) State Registrar's Signature JUN 23 Registrar

10-04747	
Jacob Stewart	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

acob Stewart	1.	State of Maryland /	Departific	nent of neath cate of Death	and Mema		_{3. No.} 2010	21513
Physicia		egistrar I. Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death 1245 hrs
Medical Exami	ner	Jacob Tyler Stew	art	10.00.70	- ar Longtion of F	June 24, 20	010 4c. County of Death	
		4a. Facility Name (if not institution, give street and number) 306 Dr. Jack Road		Port De	•		Cecil	
Funeral Director		5. Social Security Number 406 – 37 – 4978 6. Sex 1 — 7. Age	(In yrs. last b	irthday) If Under Months	1 Year If Under 2 Days Hours	Min. Dec. 2	2. 1986 Co	thplace (State or n Maryland untry)
,		Usual Residence of Decedent 10a, State 10b, County	10c. City, Tov	vn or Location				10d. Inside City Limits
ط الاساس ها		Maryland Cecil		Port [eposit			1 Yes 2 No
Maryland 28a-f show any <u>d at once.</u>		10e. Street and Number		10f. Zip 0	ode	10	g. Citizen of What Cou	
with the Maryland ns 23a or 28a-f sho be notified at once.		306 Dr. Jack Road	1 O		21904	? (Specity Yes or No-	U.S.A	e ican Indian, Black,
ath wit items 2		11. Marital Status 1 X Never Married 2 Married Armed Forces?	No No	If Yes, specify	Cuban, Mexican, P	uerto Rican, etc.)	White, etc.	
ifter de ul", or ner mu	Dy Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:			No specify:		Specify: WY	nite
hours a		15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5		 Decedent's Usual O during most of work 	ccupation (Give kir ng life. DO NOT us	nd of work done se retired)	Amtrak	industry
36 hin 72 e. than "	Completed	Twelve Years	',	Train D	ispatche		Philadelph	nia. PA
21215-0036 build be filed within 7 Mental Hygiene. marked other than ic event, the Medica		17. Father's Name (First, Middle, Last)			18.Mother's	Name (First, Middle, M	taiden Surname) Campbell	
2121 Uld be fi Mental I marked	To Be	John T. Stewart 19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address	(Street and Numb	er or Rural Route Num	ber, City or Town, State	e, Zip Code)
MD and 2 show alth and 2 m 27 is summation		John T. Stewart (father)	Too: 51	306 Dr. Ja		Port Depo	sit, Maryla	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumasic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from Sta	cren	matory or other place) Ferris & C		06/30/10	West Ches	ter. ylvania
Baltimore, permit. Pages I ar Department of Hee Important: If ite	ŀ	4 Donation 5 Other Specify: 21 Signature of Funeral Service Liceosee	Ν.Λ.	22 Name and 4	ddress of Facility		<u> </u>	
Ba Perm Depa Imp	- 1	allhoman m LOIARMIS	n. 50	Lee A.	Patterso <u>erryvill</u>	n & Son Fu e, Marylan	neral Home	P.A. 766 Approximate Interval
Physician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.					est, shock, or redict	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cocaine Due to (or as a conse		ycodone ir	toxicati	OII		
	Ļ	Sequentially list conditions, if any leading to immediate Due to (or as a conse	equence of):					1
	Examiner	Course or injury that initiated C.						4
ansit	Exa	events resulting in death) Last Due to (or as a conse				7 10010 III		
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cox 68760, eath certificate be executed attending physician and for use as the burial - transit	n/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic	pregnancy	23d. Date of delive Month	Day Year
Box 6876 te death certificate the attending phy ned for use as the	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	time of death	5 Other (Spec	ify)			
e the com	Phy	Part II. Other significant conditions contributing to deat	h but not resu	ulting in the underlying	cause given in Par		obacco use contribute t	
Records, P.O. I The law requires that the cate has been signed by the page 2 should be detache	ed by	·				[24a. Was	an 24b. Were	autopsy findings available
cords aw requas been as been 2 should	Completed			<u> </u>		autop	psy prior to ormed? death?	completion of cause of
tal Rec tian: The l certificate l	Con	25. Was case referred to medical			6.Place of Death (1 ✓ Yes Check only one)	2 No 1 🗸	res 2 No
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death. **All Directors** After this certificate has been signed by led in by the funeral director, page 2 should be detact).	n:	27. Manner of Death 28a. Date of Inj. (Month, Day.)		8b. Time of Injury	8c. Injury at Work		how injury occurred	
Ivision or Attendi after death Director:	catio	Natural 5 Pending Investigation Fd 6/24	/10 F	d 12:30 pt ne, farm, street, factory		28f Location 6	(Street and Number or I	Rural Route Number, City
Division of Vital pital or Attending Physician: ours after death. eral Director: After this certif filled in by the funeral director,	Certification:	3 Suicide 6 X Could not be determined (Specify) 16				Port De	State 306 Dr. Posit, MD	Jack Rd
Hos 24 h	1	29a. Certifier 1 Certifying Physician: To the best of n (Check only one) 2 Medical Examiner: On the basis of examiner:	amination and	e, death occurred at the	time, date and pla opinion, death occ	ce, and due to the cau curred at the time, date	ise(s) and manner as st e and place, and due to	ated. the cause(s)
To the within To the comple	Medical	29b. Signature and title of certifier			. License number		29d. Date signed (M	
		My Siame (M)			O.C.M.E.		June 25, 2010	
		30. Name and address of person who completed cause of Melissa Brassell, MD Assistant Medica			reet, Baltimore	e, MD 21201		
	State	22 Pogietr	ar's Signature					
Regi			A	sules				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 JUNE 18 10:30 AM TAYLOR RUTHIE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S MAGNOLIA CENTER LANHAM Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours Min MARCH 29 1945 SOUTH CAROLINA 577-62-6341 65 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location MD LANHAM 1X Yes 2 ☐ No PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 5502 OAKBROOK PLACE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedon. Armed Forces? · ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE ADMINISTRATION 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BARBER CLARENCE BRICE MAGGIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5502 OAKBROOK PLACE, LANHAM, MD 20706 KENNETH J. TAYLOR/ SON 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State RESURRECTION CEMETERY 06/25/2010 CLINTON, MARYLAND 4 ☐ Donation 6 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility e of Fundal 5 rvice Licensee 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MONTHS Immediate Cause (Final METASTATIC GALLBLADDER CANCER disease or condition resulting in death) Due to (or as a consequence of): MONTHS END STAGE RENAL DISEASE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Vear Day Pregnant at time of death 1 ☐ Yes ∠ ¥ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 No 1 Yes 26. Place of Death (Check only one) Hospital Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Examiner ig physician and as the burial-transit requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending nse for detached signed by pe page 2 should Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has leted filled in by the funeral director, page 2 s within 2 To the I

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Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 1 Tes 27. Manner of Death 28a. Date of injury (Month, Day, Year) injury work? 1 🗌 Yes 2 🗆 No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

only one) 29b. Signatu e and title of certifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAKESH ARORA M.D 14300 GALLANT FOX LANE # 222 BOWIE, MARYLAND 20715

State Registrar 32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JUNE Physician/ 2010 2:55 P ELEANOR TAYLOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3800 ENFIELD COURT # PRINCE GEORGE'S BOWIE Date of bill. (Month, Day, Yea 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Min. NEW YORK 117-24-8370 76 Director APRIL Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director ms 23a or 28a-f s must be notified Yes 2 No MD PRINCE GEORGE'S BOWIE 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral USA 3800 ENFIELD COURT # 315 20716 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian "natural", or iter edical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2**X** No Yes Baltimore, Maryland 21215-0036 BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: 3 Divorced Completed other than "natu rent, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE SECRETARY 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked of traumatic eve မ LAURA TAYLOR JOSEPH MURPHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 i 2008 E. MARSHALL PLACE LANDOVER, MARYLAND 20785 DAVID MURPHY/COUSIN other 1 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) injury or 6/24/2010 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY Sign ture of Funeral Service 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIABETES MELLITUS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYPERTENSION if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): HIGH CHOLESTEROL or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical RENAL INSUFFICIENCY attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year ☐ Pregnant at time of death ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2 💢 No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760 P.O. I Records, Division of Vital s after death.

DHMH 17 Rev 7/2009

State Registrar

сотретер

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

.D

TANENHOLZ

1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

22

BOWIE, MARYLAND 20716

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

14999 HEALTH CENTER DRIVE # 201

		•	1 - For State Registrar	State of M	1arylan		artment of tificate of				giene _{Reg. No} 2 (010	21516
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	Medio Examir		4a. Facility Name (if not institution Mon topomery General	n, give street and number)			4b. City, Town,	or Location	of Death	June 20	4c. Cou	nty of Death	
	uneral		5. Social Security Number	6. Sex 7. A		ast birthday)	If Under 1 Yea Months Days	r If Unde	er 24 Hrs.	8. Date of Birt	h	9. Birth	nplace (State or Foreign
	irector		219-72-0710 Usual Residence of Decedent	1 ¹ M 2 □ F	52	Yrs.	Worths Days	Hours	IVIIII.	Jan 25,	1958	Cou	New York
aryland	a-f sho	ector	10a. State 10b. County Maryland Monto	gomery		, Town or Loc Silver S							10d. Inside City Limits 1 ☐ Yes 2 No
h the M	sa or 28 be noti	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizen o	of What Cou	
eath wit	tems 2; er must	-uner	4017 Jeffry Stre	12. Was Decedent			Vas Decedent of	Hispanic O	rigin? (Spe	cify Yes or No-	USA 14. R	ace - Ameri	ican Indian,
036 s after d	ral", or i Examin	by	1 🛣 Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Van City			Yes, specify Cut			Rican, etc.)		lack, White ify: Whit	
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/land	irked ot tic ever	To B	17. Father's Name (First, Middle, Francis A. Thomp					18. Mot		e (First, Middle, ne L. Iri		me)	
Mary 2 should	27 is ma r trauma	Ŷ	19a. Informant's Name/Relations Suzanne L. Thomp				g Address (Stree Jeffry S				-		Code)
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after	Important if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cematics 4 Donation 5 Other (3 Reproval from State	20b. Pl	ace of Dispos	sition (Name of latory or other pla ven Ceme L	-	June		20c. Locatio	n - City or T	own, State J, Maryland
Balti permit.	Importa any inju		21. Signature of Fundral Stylic	rens e		F	Name and Addr rancis J. O Univers	Collin	as Fun	eral Home	Inc.	/m 2090	11
			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that cause only one cause on each lin	d the death e.							2020	Approximate Interval Between
, M	sician/ ledical	e i	Immediate Cause (Final disease or condition resulting in death)	a. Acute Myo			ction					-	Onset and Death
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SO :e be exe	physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as	a conseque	erice or,.							
Box 68760 death certificate b	nding ph use as th	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. [Date of deliv	/ery
ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be executed at death.	been signed by the attending should be detached for use as	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 4 Pregnant a 9 Unknown			Ectopic pregnar Other (specify)	ncy				/lonth	Day Year
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the is after death.	signed t	þ	Part II. Other significant conditi Hypertension, Hyp		out not resu	Ilting in the ur	nderlying cause g	iven in Par	t I.				the cause of death?
Cord	as beer 2 shou	Completed								24a. Was a autop	sy	prior to co	opsy findings available ompletion of cause of
al Re an:⊺he	certificate has t lirector, page 2 s		25. Was case referred to medical				26. F	Place of Dea	ath (Check	1 🗌 Yes	med?	death? 1 Yes	2 🗌 No
f Vit . Physici	this cer al direc	욘	examiner? 1 Yes 2 X No 27. Manner of Death	Hospital: 1 Inpat 28a. Date of inju		R/Outpatient 28b. Time of	3 □ DOA Oth	ner: 4 \square N	lursing Hor	me 5 Resid			y)
on o ending eath.	or: After he fune	Certificate	1 X Natural 5 ☐ Pendii 2 ☐ Accident Investi	ng <i>(Month, Da</i> igation	y, Year)	injury	28c. Inju wor M 1 [ryat k? Yes 2	_	28d. Describe ho	ow injury occu	ırred	
DIVISI alor Att safter d	Il Directo		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ			ne, farm, stre	et, factory, office		2	28f. Location (Si City or Town		ber or Rura	I Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death.	ne Funera pleted fille	Medical	(Check 2 \square Medical I	Physician: To the best of Examiner: On the basis of a Nurse Practioner: To the	examination	and/or investi	gation. In my opin	ion, death c	occurred at	the time, date an	nd place, and c	tue to the ca	use(s) and manner stated.
Z withi		— r	29b. Signature and title of certifie		50	27	29c. Licens		32		29d. Date sign		
			30. Name and address of person Rebecca M. Gross				int) enue, #600	5, Kens	singta	n, MD 208	95	, 10	
R	Stat legistra	~	31. Date filed (Month, Day, Year) JUN 23		ar's Signatu	fre face	2						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2100 PM Stuart Edward 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death. HICOMICO TENINSULA 5. Social Security Number 8. Date of Birth (Month, Day, Year) 03-05-1926 Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Days 1 M 2 F Hours 214-22-8299 Maryland 84 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b County 10a, State 10c. City, Town or Location 10d. Inside City Limits Directo 1 Z Yes 2 No MD Somerset Marion Station 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27471 Coulbourne Creek Road 21838 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give W Black, White, etc. 1 Never Married 2 Married þ Year or Dates. WWII 1 ☐ Yes 2 Z No Specify: Whita 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Space Flight Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence R. Tull Anna Fitzpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Brown Tull/wife 27471 Coulbourne Creek Road, Marion Station, MD 21838 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 06-25-2010 Clinton, Maryland Signature of Funeral Service Licensee 22 Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., ,M00295 Princess Anne, MD Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ofnier Physician/ disease or condition Medical resulting in death) e to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical 23c, If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 1 🗌 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 PER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Natural
2 Accident
3 Suicid 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 6-20-10 15+1 who completed cause of death (Item 23a) (Type, Print) 30434-1400 mt. Vernin Rd. Princers Anne, Md. 21853 Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

		For State	State	of Maryl	and / Dep	artment of H	lealth and N Death	Лental Нус	giene 2	010	21518
		Registrar 1. Decedent's Name (First, Middle	, Last)			- Inouto of B		2. Date of Dea			3. Time of Death
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Exami		4a. Facility Name (if not institution,	give street and nu	mber)		4b. City, Town, or	Location of Death		4c. Cou	nty of Deal	th
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Funeral Director		5. Social Security Number 215-96-8366	6. Sex 1 ☐ M 2 🎇 F	7. Age (in y	74 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day 03/09/	n / Year) / 1036	9. Bir Co	thplace (State or Foreign Belarus
	1	Usual Residence of Decedent			_/+			1 03/09/	1930		Delaits
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medic		xaminer: On the ba	asis of examina			time, date and place	ce, and due to the		manner as	stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 1 0 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death Physician/ $20\overset{\text{Year}}{10}$ June Franklin R. Williams Sr. 1:00₺ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 206 Dodson Dr. Ceci1 Rising Sun Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav. **Funeral** Hours (Month Day, Year) OV 8 1932 1 🛛 M 2 🗆 F 219-28-4173 77 Director Nov Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ¥ Yes 2 □ No MD Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 Dodson Dr. 21911 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married □Xes 2 □ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: 3 Widowed 4 Divorced "natural", Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Pastor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marshall Williams Tracie Ayers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4860 Cornsilk Terrace North Port, FL 34286 Frank R. Williams/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 6/24^P72010 cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, MD Name and Address of Facility .T. Foard Funeral Home, P.A. 11 S. Queen St. Rising Sun, MD 21911 21. Signature of Funeral Se in Thensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease r condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No cate has been signed by the page 2 should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No Yes funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗌 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending Natural Accident work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: After pleted filled in by the fun Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed within 2 29b. Signature and title 010

State Registrar

6+1VA

30. Name and addre

31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

eted cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar 21520 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Alexander Wongus June 19 2010 2:55 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Wicomico Nursing Home Salisbury 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth Funeral 1 🖾 M 2 🗆 F Months Days Hours Min. Dec. 13, Year) 89 Maryland 214-12-5989 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No MD Mardela Springs Wicomico 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? HEX ONDEL WOND U. Baltimore, Maryland 21215-0036 Funeral items 23a 9829 Wallertown Road 21837 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or ģ 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) B&G Pickle Company 6th Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Wes Sampson Ella Mae Wongus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 9829 Wallertown Road-Mardela Springs, MD 21837 Geneva Wongus/ Wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Mt. Pleasant UMC Cem. 06/23/2010 | Salem, MD 4 Donation 5 Other (Specify) of Funeral Service License 22. Name and Address of Facility Salisbury, Maryland any Chapel - 1213 Jersey Road 21801 Jolley Memorial Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Sequentially list committees, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed bunal-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buna Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Other (specify) Pregnant at time of death signed by the a d be detached f g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available 24a. Was an page 2 autopsy prior to completion of cause of death?

1 Yes 2 No this certificate 25. Was case referred to edical examiner? Division of Vital 26. Place of Death Check only one) funeral director Be Hospital Other: 1 Tyes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural injury 5 Pending work?
1 Yes hours a er decth. neral Director: Al 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours a To the Funeral Discompleted filled Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D. 910 Easternshore Dr Salisbury MD 21804 32. Registrar's Signa 31. Date filed (Month, Day, Year) State JUN 2 3 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2010 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:45 AM JUNE Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner Ba + Maryland Medical Center ALTIMORE (timove 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day try) Director shov 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Wes 2 No HEBRON WICHMICE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral COITZAN 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION should be filed with and Mental Hygier 7 is marked other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မ UTHER WEBSTER MRGARET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAM WEBSTER (WIFE 5986 REWASTICO RD HERPON, MD 121830 Baltimore, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place PRINGHILL MEMORY GARDENS 6-26-10 HEBPON-MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BSICKFUNERALHOME PO BOXGI BIVALVE, MD 21814 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Pulmonary Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (c) se a possecuence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed and trar Due to (or as a consequence of): attending physician of for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached g Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes Records, 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available this certificate has ral director, page 2 autopsy prior to completion of cause of death?

1 Yes 2 No Yes 2 No 25. Was case referred to medica Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No Hospital ၉ 1 PInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After iniury work?
1 Yes 2 No Natural 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 [only one) 29b. Signature and title of certifier ٩ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Themas L. >
31. Date filed (Month, Day, Year)

JUN 25

2. Registrar's Sign

South, Greene St.

			For State Registrar	State of Ma	ryland	7 Depa Cer	rtment of F tificate of L	Health and M Death		giene Reg. N		21522
	Physicia Medic		Decedent's Name (First, Middle, Last) ERNEST			W.	ASHINGTO	N	2. Date of De Month JUNE		ay Year 9 2010	3. Time of Death 20:30 PM
4	Examin		4a. Facility Name (if not institution, give s				4b. City, Town, or	Location of Death		40	c. County of Death	
	.^ 		SUBURBAN HOSPITA 5. Social Security Number 6. Sex		(In ure las	st birthday)	BETHESI If Under 1 Year	OA If Under 24 Hrs.	8. Date of Birt	th	MONTG	OMERY place (State or Foreign
	Funeral Director			M 2 □ F	72	Yrs.	Months Days	Hours Min.	09/07/	193	Coun	L CAROLINA
	and show 1 at	or	10a. State 10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City Limits
	Maryl 28a-f otified	irec	MD PRINCE GE	ORGES	NE	EW CA	RROLLTON					1X Yes 2 □ No
	with the 23a or ust be n	Funeral Director	10e. Street and Number 7729 RIVERDALE RD.	<i>#</i> 204			10f, Zip Code 2078	4		10g, C	itizen of What Cour	ntry?
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show t-dical Examiner must be notified at	Completed by Fun	11. Marital Status 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates.			√as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Specin, Mexican, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Americ Black, White, Specify: BLAC	etc.
15-(should be filed within 72 hours aft and Mental Hygiene. Is marked other than "natural", aumatic event, th. M. dical Exa	nplet	15. Decedent's Edu (Specify only highest grad	ication le completed)		(Give k	ent's Usual Occup- ind of work done o	ation during most of workin	ng	16b. l	Kind of Business In	dustry
212	within giene. er thar the N	S	Elementary/Seconday (0-12) 1 2 TH	College (1-4 or 5+)		NOT use retired) LEANER				PRIVATE	
pu	filed val Hyg	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name	(First, Middle,	Maiden	Surname)	
<u> </u>	uld be I Ment narke natic	유	ERNEST	WASHINGTO	ON	SR.		GERALDIN			HOLMAN	
Maryland	2 shouth and the and the strain traum		19a. Informant's Name/Relationship (Typ	. ,			-	and Number or Rural				
	f Heal f Heal item 2		KATIE WASHINGTON/ 20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of	E RD.#204	NEW CA		LLTON, MD ocation - City or To	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, th. M. dical I once.		1 🕅 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		RESI	JRRECT		TERY 06/28	8/2010		INTON, MA	
Bal	permit Depar Impor any in		21 stutre of neral Service Licenses	9		- 1		oss of Facility J.B				
	Physician/	K N	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause on each line.		Do not ente	r the mode of dying	g, such as cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
1	Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):						
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a	conseque	ence of):						
	uted id ansit	ami	cause. Enter Underlying Cause (visease or impory that initiated events									
8	cate be executed physician and s the burial-transii	edical Examiner	resulting in death) Last	Due to (or as a	conseque	ence of):						
98	cate b physia the b	edic		í								
26/19/10 26 P.O. Box 6876	that the death certificate be executed ned by the attending physician and detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	f pregnan Fetal time of de	cy death 3 = eath 5 =	Ectopic pregnance Other (specify)	Sy			23d, Date of deliver Month	ery Day Year
30	es that the des signed by the a be detached f	y Ph	Part II. Other significant conditions con	tributing to death but	t not resu	ting in the ur	nderlying cause giv	ven in Part I.	23e. Did to	obacco	use contribute to th	ne cause of death?
<u>, 's</u>	quires en sigr uld be	ed b	CHRONIC KIDNEY	DISEASE					1 🗆	Yes 2	No 3□ Pro	bably 4 🛚 Unknown
Record	To the Hospital or Attending Physician: The law requires i within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Completed by								osy ormed?	prior to co death?	psy findings available mpletion of cause of
a F	ian: T artifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Pla	ace of Death (Check	1 \(\superstack \text{Yes}\)	2 (2)	ioj 1 in fes	2 100
A. S.	hysic this ce al direc	은	1 ☐ Yes 2 🕅 No	ospital: 1 🔀 Inpatier				4 U Nursing Hon	ne 5 🗆 Resid	dence	6 ☐ Other (Specify)
5 5	ding F h. After 1 funera	ate:	27. Manner of Death 1 X Natural 5 Pending	28a. Date of injury (Month, Day,		28b. Time of injury	28c. Injury work M 1 🗆	yat :? Yes 2 □ No	8d. Describe h	ow inju	ry occurred	
HINGTON, ER	or Atten ifter deat virector: in by the	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At hon (Specify)	ne, farm, stre			28f. Location (S City or Tow		nd Number or Rural e)	Route Number,
WASHINGTON, ERANT Division of Vital Rec	lospital t hours a uneral E ed filled	Medical (29a. Certifier 1 Certifying Physic (Check 2 Medical Examin	cian: To the best of m	y knowle	dge, death o	ccured at the time,	, date and place, and	d due to the ca	use(s) a	nd manner as state	ed. use(s) and manner stated
3	o the F vithin 24 o the F complet	Me	29b. Signaty e and title of continue.	Practioner To the b	est of my	monteage, d	29c. License	office, data and plane	gand ous to th	а саина	(s) and marrier as st ate signed (Month)	offed
			► MXWW	1/			10	102949	7	(0/20/	10
ch	24		30. Name and address of person who co DR. NATASHA HAAG	1 1				IESDA, MD	20814		-	
	Stat Registr:		81. Date filed (Month, Day, Year) JUN-2 8 2010	"32. Registra								
					-						-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 1 - State Registrar Certificate of Death 2. Date of Death Мо Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 500 N Harry Truman Drive Largo If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Month Day Year 32 Mc Cormick, 1 🔀 M 2 🗆 F Months Min. 78 **Director** 248-46-8080 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 √ Yes 2 □ No Maryland Prince George's Largo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 20774 United States 500 N Harry Truman Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced **Black** Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed 6 Cement Mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lula Mae Searles John Posey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N Harry Truman Drive Largo, Maryland 20774 Beatrice Williams / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 😾 Burial 2 🗌 Cremation 3 🗆 Removal from State any injury or 4 Donation 5 Other (Specify) 6/25/2010 Landover, Maryland Harmony Memorial 21. Signature of Funeral Service Lice See 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 M 01085 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Other (specify) Pregnant at time of death signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably W Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy perform 1 Yes 1 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours after death.

ne Funeral Director: After this pleted filled in by the funeral d 28a. Date of injury 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at Certificate: 28d. Describe how injury occurred Year work? 5 Pending 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the F

complete з 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

29b. Signature and title of certifier

2010

ne and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

29c. License number

		-	For State Registrar	State of Maryla		artment of H tificate of D			ene 2010	21524
	Physicia	n/	Decedent's Name (First, Middle, Last)					Date of Death Month		3. Time of Death
	Medic	al	BARBARA 4a. Facility Name (if not institution, give stre	L.	W00	DS 4b. City, Town, or	I costion of Dooth	JUNE	20 2010 Year	5:15 P M
لعر	Examin	er	MONTGOMERY HOSPIC			ROCKVILI			MONTGOM	
Ī	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth SEPT 3	9. E () 1936 FI	Birthplace (State or Foreign Country) ORIDA
			Usual Residence of Decedent					<u> </u>	0 1930 11	
	ryland -f sho ied at	Director	10a. State 10b. County		City, Town or Loc					10d. Inside City Limits 1 → Yes 2 → No
	he Ma or 28a o notif	Dire	MD MONTGOMER 10e. Street and Number	Y GE	RMANTOW	N 10f. Zip Code		1	0g. Citizen of What 0	
	s 23a uust bo	Funeral	21000 FATHER HURLE	Y BLVD		20874			USA	
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	2. Was Decedent Ever in to Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If	Vas Decedent of Hir Yes, specify Cubar	n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. BLACK
Maryland 21215-0036	72 hou n "natu Aedical	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give I	lent's Usual Occupa kind of work done d O NOT use retired)		ng	16b. Kind of Busines	ss Industry
212	within rgiene. rer tha t, the I		Elementary/Seconday (0-12)	College (1-4 or 5+)	1	CRETARY			PRIVATE	
and	ntal Hy red ott	To Be	17. Father's Name (First, Middle, Last) JAMES THURSTO	ON			18. Mother's Name			
aryli	nould but my Me s mark		19a. Informant's Name/Relationship (Type,		19b. Mailir	g Address (Street a			City or Town, State, .	Zip Code)
Σ	nd 2 sh ealth a m 27 is		CAMMYE JENKINS/DG				RM WAY G		URG,MARYL	
Jore	ge 1 and tof Hitch		20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Re	emoval from State		natory or other plac	e) :		20c. Location - City ERMANTOWN	
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral service Licensee	AL		CEMETERY . Name and Addres			NS FUNERA	
ñ	permir Depar Impor any ir	k ili	AV						R,MARYLAN	
	Pnysician/ Medical		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	cause on each line. METASTATIO	C BREAST			r respiratory arres	st,	Approximate Interval Between Onset and Death 1 MONTH
-	Examiner			Due to (or as a conse PRIOR EARI		BREAST (CANCER			5 1/2 YEARS
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):					
	ate be executed physician and the burial-transit	Exan	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a conse	equence of):					
9	e be e iysiciar ne buria	dical	d.							
. Box 687	death certific ne attending ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 N No 9 Unknown	c. If yes, outcome of preg 1 Live Birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of o Month	delivery Day Year
ds, P.O.	requires that the de been signed by the should be detached	þ	Part II. Other significant conditions conti	ributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.			to the cause of death? Probably 4XI Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Completed						24a. Was ar autops perforr 1 \(\subseteq \text{Yes} \) 2	v prior t	autopsy findings available to completion of cause of ? Yes 2 X No
Vita	ysiciar s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 【 No Ho	spital:	☐ ER/Outpatier	Othe	ace of Death <i>(Checi</i> er: 4 Nursing Ho		ence 6 🛣 Other (Sp	ecHOSPICE
of	ing Ph After thi uneral		27. Manner of Death 1 X Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of	28c. Injury work	/ at ?		w injury occurred	
sior	Attend r death sctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At			Yes 2 □ No			Rural Route Number,
ΟĬ	ital or afte al Dire		4 Hottilicide determined	building, etc. (Spec	cify) 			City or Town	, State)	
	e Hospital	Medical	(Check 2 Medical Examine)	ian: To the best of my knor: On the basis of examina Practioner: To the best of	tion and/or inves	tigation, in my opinio	on, death occurred a	the time, date an	d place, and due to the	ne cause(s) and manner stated.
_	To the within 2 To the comple	~	29b. Signature and title of certifier			29c. License	number		9d. Date signed (Mo	onth, Day, Year)
			JAWWXH	menul	m 22a) /Firs		7236		JUNE 22	, 2010
2_	. 2		30. Name and address of person who com CAROLYN B. HENDR	npleted cause of death (It ICKS M.D. 6			IVE # 506	BETHESI	DA,MARYLAI	ND 20816
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 4 2010	32. Registrar's 3 ig	park	,				

		1- For State Registrar		Ce	rtificate of	f Death			Reg. N	lo.		
Physic	ian/	1. Decedent's Name (First, Midd	dle,Last)						e of Death			3. Time of Death
Medical Exam	iner	MICHAEL EUGEN	E WILLIAM	5				Jun	e 13, 2010			0725 hrs
		4a. Facility Name (if not institution 20010 Zion Road	on, give street and n	umber)		4b. City, Town, o		Death		4c. County of Montgon		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Yea	ar If Under	24Hrs. 8. Da	ate of Birth (M	M/DD/YYYY		place (State or
Director		1 zlem	1X M 2 F	52	Yrs	Months Day	/s Hours	Min.			Foreign	
		Ukn Usual Residence of Decedent	183 W 2	52		·	لـــــــا		2/11/1	.936		ntry) DC
any		10a. State 10b. County		10c. City	, Town or Locat	ion	-					10d. Inside City Limits
* .	L	MD Montgo	omerw	Gai	thersbu	ra						1 Yes 2 X No
Aaryland 28n-f show Lat once,	ţō	10e. Street and Number	and Ly	Gai	. CLET SDU	10f. Zip Code	·	-	100.0	Citizen of Wh	at Count	
th the Maryland 23a or 28n-f sho	ire		-						109.	JANZEN ON VVII	at Count	ıyı
th the 23a c	Funeral Director	20010 Zion Roa				20882				SA		
th wi	hera	11. Marital Status 1 X Never Married 2 M		cedent Ever in U. orces?		s Decedent of Hi es, specify Cuba				14. Race White		an Indian, Black,
er dea	Fu		1 Yes	2 X No								
s after rral", nince	by		vorced If Yes, Give Ye		1	Yes 2 No		. i - i		Specify:		
15-0036 filed within 72 hours after death with the Maryland for thygiene. d other than "natural", or items 23a or 28a-f she is, the Medical Examiner must be notified at once	Completed	 Decedent's Education (Spe Elementary/Secondary (0-12) 		1-4 or 5+)		t's Usual Occupa ost of working life			ne libr	. Kind of Bus	siness/in	dustry
5-0036 led within 72 Hygiene. other than the Medical	ple	10th	College (1-4 01 3+)	Disabl	50			N	ion.		
with with been the table	om o	17. Father's Name (First, Middle	Last)		DISCOIL	cu	18 Mother's	Name (First, I		one	-	
15. Filed at the color of the c	ВеС	Warner William						lyn Re		on ourname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To B	19a, Informant's Name/Relations			19b. Mailing	Address (Stree				City or Town	State	Zin Code)
sho and and and is	-	Warner William		father		0 Zion I				-		
e, M l and 2 Health item 2		20a. Method of Disposition		20b. I	Place of Dispos	ition (Name of ce		Date		c. Location -		
Baltimore, sernit. Pages I ar Department of Hes Important: If ite injury or other tr		1 X Burial 2 Cremation	n_3 Removal fr	on oraco	crematory or oth							
t. Partimentant		4 Donation 5 Other S		/ As		ial Cem.		6/19/1	0 <u> </u> S	andy S	pri	ng, MD
Baltimo permit. Page Department Important: injury or otl		21. Si ina ure of Funeral Servi	nsee	rt al		ame and Address						
	\vdash	23 Part I. Enter the lisease, or	compleations that of	raused the death		6 N. Was						20850 Approximate Interval
Physician /Medical		failure. List only one cause	on Ach line.		()			alac or respire	atory arrest, s	niock, or nea	"\ [Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)		ve Atherosci		ovascular Dis	sease					Death
			Due to (or as a	a consequence o	t):						l	
	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequence of	f):				-			
	i	cause. Enter Underlying Cause (Disease or injury that initiated	c									
sit sd	Examiner	events resulting in death) Last	Due to (or as a	consequence of	f):							
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed releath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit			d									_
O, be es siciar	/Medical	UNPENDED	AMENDED									
76 ficate g phy	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,	outcome of pregr					2	3d. Date of o		V
certil	iar	past 12 months?		ointn nant at time of de	2 Fet		Ectopic p	regnancy	Ī	Month	Da	y Year
Box 68760, he death certificate but the attending physic hed for use as the bur	Physiciar	1 Yes 2 No 9 Uni	known 9 Unkn		5 Otr	ner (Specify)			— i			
O. I tr the		Part II. Other significant condit	tions contributing to	death but not re	sulting in the u	nderlying cause g	given in Part I	I. 23	e. Did tobacc	o use contrib	oute to th	e cause of death?
ords, P.O. w requires that the second second by should be detach	ğ	Diabetes Mellitus						1	Yes 2	No 3 €	Proba	bly 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed	0						24	a. Was an			psy findings available
COF law 1 has t	e e							-	autopsy perform <u>ed</u>	? de	rior to co ∋ath?	mpletion of cause of
tal Rec rian: The l certificate l	Ö								Yes 2	No 1	✓ Yes	2 No
ician: s certif rector,	æ	25. Was case referred to medica examiner?	Magnital, -				Other	heck only one	'		7	
F Vi Physi r this	ျ	1 ✓ Yes 2 No		Inpatient 2	ER/Outpatient			lursing Home		dence 6		Scene
ing Ph After After funeral	崩	27. Manner of Death 1 ✓ Natural 5 □ Page		of Injury , Day,Year)	28b. Time of Ir		ry at Work?		escribe how in	njury occurre	d	
SiOr ttenc death death ctor;	äţ	≓ J Penc	stigation				res 2 No					
IVIS For At after d Direct	ertification:		d not be	e of Injury - At ho	ome, farm, stree	t, factory, office b	ouilding, etc.		cation (Street Town, State)	and Numbe	r or Rura	il Route Number, City
Di spital hours a neral I	Š	4 Homicide	rmined (Specify)					Air .				
To the Howithin 24 h	<u>8</u>	29a. Certifier (Check only 1 Certifying Pl	hysician: To the bes	st of my knowledg	ge, death occum	ed at the time, da	ate and place	, and due to t	he cause(s) a	and manner	as stated	I.
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ,	Medical		miner: On the basis of and manner s	tated.	idioi irivestigati			ned at the tim				
	Σ	29b. Sonature and title of certifie	n			29c. Licens				I. Date signe	,	h, Day, Year)
"		(Spental	DINIA)			O.C.I	M.E.		Ju	ne 13, 20	10	
		30. Name and address of person				_						
			ssistant Medica			Street, Baltin	nore, MD	21201				
S Regis	ate	31. Date filed (Moeth, Day, Year)	1040 LA	egistrar's Signat	re park							
7/2/1/2	48-18	~ U (LUIU LICYU		C. A.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 6 1 0 21526 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Frances Curfman Winston June 21, 2010 6:50 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Galtnersburg

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Gaithersburg Montgomery 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F May 19, 1924 Director 225-28-8346 86 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County if than "natural", or items 23a or 28a-f show the Medical Examiling at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 415 Russell Avenue, # 1013 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Inc.) Docent Smithsonian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Leslie Curfman Julia Fitchett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. H. Scott/ Cousin 4301 Townsend Drive, Cape Charles, Virginia 23310 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 6/22/2010 | Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Adult failure to Thrive Immediate Cause (Final **Physician** Memonth disease or condition resulting in death) /Medical Due to (or as a configuence of): Examiner Protein Caldre if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) be executed burial-transit salto alimen that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical law requires that the death certificate attending philosophia as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 MNo the 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 has been si je 2 should t Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page The certificate of Vital 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p 2 . Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 / Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) > He Dabert Dirschboch und June 21, 2010 04115

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14. ROBERT DIRSCHBALL, MA

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #1 1 - State Registrar MD, TCHD, 6/23/10 pha Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Month MARJORIE NAAS WILLIAMS AM 19 2010 8:25p 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot William Hill Manor Easton . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 F 10-7-1915 Hours 073-07-3856 94 **Director** New York Usual Residence of Decedent should be filed within 72 hours after deau where the within 72 hours after deau when the Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director Md Talbot Easton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 Dutchmans Lane 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3 XWidowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Ruliffson Oliver L. Naas and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Jenkins daughter 25696 Royal Rd. Royal Oak, Md. item Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Capitol Crematory 6-21-2010 Dover, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hurley P O Bo & Ostrowski Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician. Medical resulting in death) a consequence of): Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) ng physician and as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Box 68760 IF FEMALE: use 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo Month Day Year Pregnant at time of death 1 ☐ Yes ∠-∟ 9 ☐ Unknown cate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 2 No မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending work? Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners, the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of cert 29c. License number 29d, Date signed (Mogth, Day, Year) D25750 21 10 Robert Sanchez who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (MonJUN 2 3 2010

		Pleas	se Type or Pri).
		for State	State of M	aryland / [Department of I				2152
		Registrar 1. Decedent's Name (First, Middle	(a a f)		Certificate of	Death		Reg. N2 0 1 U	
Physic	ian	Robert Arbaugh	, Last)		N		2. Date of De Month	Day Ye	
/Medi Examiı		4a. Facility Name (If not institution,	give street and number)	4h City Town	or Location of Death		4c. County of D	
= Examil	ner		rare Hos	oi ta	1 8 25	dola	1		more
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last bir		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 9.	Birthplace (State or Foreign Country) In K
Director		213-30-9158	1 🕅 M 2 🗆 F	77	Yrs. Months Days	Hours Min.	May 18	, 1933	CountryLITE
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location				10d. Inside City Limits
Marylan I-f show	tor	MD Balt	imore						1 □Yes 2 → No
h the	irec	10e. Street and Number	-		10f. Zip Code			10g. Citizen of What	Country?
be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or tiems 23a or 28a-f show event, the Medical Evan the first the notified at	Funeral Director	6600 Ridge Ro	ad		21237			USA	
er dea tems	nue	11. Marital Status unk	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) 2	Ever in U.S.	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Race - A Black, W	merican Indian,
s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1 ☐ Yes 2 ☑ No		, , , , , , , , , , , , , , , , , , , ,	Specify: W	
thou	ed	15. Decedent's	Year or Dates:	16a.	Decedent's Usual Occup	nation un		16b. Kind of Busine	
hin 72 9. Medi	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5		(Give kind of work done life. DO NOT use retire	during most of worl d)	king	TOD. TOTAL OF BUSINE	33/modatry
d wit	Completed	unk	unk					_	
be file d oth eveni	Be	17. Father's Name (First, Middle, L	ast) unk			18. Mother's Nam	e (First, Middle,	Maiden Surname)	unk
y Nould	은								
permit. Pages 1 and 2 should be filed within 75 bearment of Health and Mental Hygiene. Important: if item 27 is marked other than "nn any Injury or other traumatic event, the Medicone.		19a. Informant's Name/Relationshi Sandra Wilfon		r 19b.	Mailing Address (Street 102 0 Neill	and Number or Ru St; Havi	ral Route Numbe re de Gr	er, City or Town, Stat ace, Mary	e, Zip Code) 1and 21078
t Heal		20a. Method of Disposition		20b. Place of	Disposition (Name of		Date	20c. Location - City	
Pages lent o nt: If i		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 🖾 Other (Spe	Removal from State	cemeter	y, crematory or other plac	ce)		,	·
partin porta		21. Signature of Funeral Service L			22. Name and Addre	ess of Facility		TT Delet	more Street
		Lanil	1 Hanks			re, Maryl			more Street
		23a. Part 1. Enter the disease, or c shock, or heart failure. List of	omplications that caused	I the death. Do n	not enter the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	- HYDO	alve	e mia				Onset and Death
/Medical Examiner		resulting in death)	Die to (or as	a conse y ence o	of):	W			
	ē	Sequentially list conditions,	b. Djab	etes a consequence o	melli	tus_			
tuted d ansit	Examiner	Sequentially list conditions, any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consiquence o					
be executed sician and burial-transit		resulting in death) Last	C Due to (or as	a consequence o	of):		· · · · · · · · · · · · · · · · · · ·		
eath certificate be er attending physician for use as the burial	Physician/Medical		d			<u></u>			
ertific ding p	Mec	IF FEMALE:			—				
atten for us	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnanc	y		23d. Date of Month	delivery Day Year
the d	ysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ☐ Other (specify)	·			,
s that		Part II. Other significant condition	s contributing to death bu	ut not resulting in	the underlying cause give	en in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
aquire en siç ould b	Completed by	Chronic R	enal ta	ilure			1 □ Y	′es 2 No 3 □	Probably 4 🗆 Unknown
law re as be 2 sho	plet	Coronary	Astery	Dis	e95e		24a. Was a		autopsy findings available to completion of cause of
: The cate by page	Соп	_					perfor	med? death	1?
iclan certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Deat	h (Check only o	ne)	
Phys r this ral dir	٦.	1 Yes 2 No 27. Manner of Death	1 Inpatie		patient 3 DOA Oth	4 Li Nursing Ho		lence 6 Other (S	pecify)
nding th. : Afte e fune	tion	1 Natural 5 Pending 2 Accident investigat	(Month, Day	(Year)	jury Worl	Yes 2 □ No	zou. Describe n	ow injury occurred	
Atter	iffice	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inju	ry - At home, farr	m, street, factory, office		28f. Location (S	itreet and Number or	Rural Route Number,
tal or rs afte al Dir	Certification: To	4 Hornicide	building, etc	. (Specify)		1	City or Tow	n, State)	
Hospi 4 hou Funer tely fill		(Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of	of my knowledge, examination and	death occurred at the tir	me, date and place,	and due to the	cause(s) and manner	r as stated.
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director.	Medical	one) 29b. Signature and title of certifier	and manner sta	ted.	29c. Licenso			29d. Date signed (Mo	
F 3 F 8		Aug at (19:11 8	www.		36663	1		102/2510
	-	30. Name and address of person wh	o completed cause of de	eath (Item 23a) (T		20067			1-42
	;	Dr. Stuart W	1/05 900	o Fran	** '	ue Deme	Rall	imore. M	N 2 1327
Stat		31. Date filed (Month, Day, Year)		's Signature				111110101	
Registra	ır	JUL 12	2010 Lens	wa B.	parkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** BLALOCK 2010 30pm JUL /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City. Town, or Location of Death Examiner SHIPPING MD BALTIMORE COUNTY LACE DUNDALK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, May 18, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**)** M 2□ F Northy)Carolina 66 240-68-5922 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Examination is suiffed at 1 ☐Yes 2x No Director MD unda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT ace Biz USA Funeral Dino Z 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 ☒ No ₫ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) transportation cab driver permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1111k Be Isabell Blalock ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony White - son 101 North Avondale Road; Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5型Other (Specify) in state 21. Signature of Function Parties 22. Name and Address of Facility
State Anatomy Board; 655 West Baltimore Street
Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART ONGESTIVE FAILURE Physician /Medical Due to (or as a consequence of): Examiner DIABETES if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed HYPERTENSION physician and s the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical attending p for use as as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has page 2 autopsy performed? 1 □ Yes 2 No certificate Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To After this funeral c Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 2 Accident 5 Pending nours after death.

neral Director Aff
y filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled 1× Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in the product of the cause of examination and or investigation. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D64116

Registrar

LAURA HANYOK MD 31. Date filed (Month, Day, Year)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERN AVE, BALTIMORE, MD 21224

ORIGINAL

			Amend 20a:	ase Type or Pri					All Copies Mental Hyg 10, WS		gible.
	Physicia		Registrar 1. Decedent's Name (First, Middle S	Last) B	achs	Certific	cate of L	<i>Death</i>	2. Date of De Month	_	3. Time of Death
	Medie Examir		4a. Facility Name (it not institution Northwest Hos		w/		City, Town, or Randa11	Location of Dea	ath	4c. County	of Death
	Funeral Director		5. Social Security Number 215-76-3394	6. Sex 7. Ag	e (In yrs. last birth	nday) If t	Inder 1 Year oths Days	If Under 24 Hr Hours Mir		h	9. Birthplace (State or Foreign Mary Land
		or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	1				10d. Inside City Limits
	he Maryla or 28a-f	Direct	MD 10e. Street and Number		Balt	imore	f. Zip Code			10g. Citizen of \	Yes 2 No
	ath with tems 23a	Funeral Director	740 Poplar Gro	ove; Apt 1A	ivor in LLC		21216	anania Ovlaina (i		USA	
9000	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 X Mar 3 Widowed 4 Divorced	ried Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	No	If Yes,	specify Cubar es 2 🖾 No	n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		e - American Indian, ck, White, etc. black
21215-0036	ithin 72 ho ene. r than "na rhe Medic	Completed		college (1-4 or 5	i+)	(Give kind o life. DO NO	Usual Occupa f work done di Tuse retired) nechani	uring most of w	orking		usiness Industry industry
	should be filed within 72 h and Mental Hygiene. 7 is marked other than "! rraumatic event, the Med	To Be	17. Father's Name (First, Middle, I Charles Brook	ast)		iaco ii			ame (First, Middle, I Johnson		
, Maryland	and 2 should Health and N tem 27 is ma other trauma		19a. Informant's Name/Relations Stephanie Br						ural Route Number Baltimore		State, Zip Code) .and 21229
Baltimore,	~ 0 4- 1-		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (\$	3 ☐ Removal from State		, crematory	or other place	7/8	Date /2010	Baltimore	City or Town, State
Balt	permit. Page Department Important: I any injury o		21. Signature of Fundamental Prices	dense aylor		22. Ba	Ate An	ercomy D	P. Close Fi Card; 65 1and 212(w Dai	rvices 5126 Helair 6
	hysician.		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that caused nly one cause on each line	the death. Do no	ot enter the		, such as cardia			Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	consequence of	n):	-0,0			_ W . C	
	executed an and rial-transit	Examiner	Sequentially list conditions, if my local section of cause. Enter Underlying Cause (Disease or iinjury that initiated events	Other to for as a	t our marquence ut	(jol					
90	ris e	-1	resulting in death) Last	Due to (or as a	consequence of):					
	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant at g Unknown	2 - Fetal death		pic pregnancy er (specify)	1			te of delivery nth Day Year
	s tha gnec oe de	þ	Part II. Other significant condition	ns contributing to death bu	ut not resulting in	the underly	ring cause give	en in Part I.			ibute to the cause of death?
Division of Vital Records,	≥ Q \	Completed					<u>-</u>		24a. Was a autop: perfor 1 □ Yes	med?	Nere autopsy findings available prior to completion of cause of death?
/ital	Physician: this certific ral director, I		25. Was case referred to medical examiner?	Hospital:			Other	ce of Death (Che	eck only one)	/	Jurny ()
n of \	ding Phy h. After this funeral c		27. Manner of Death	28a. Date of injur (Month, Day,		me of ury	28c. Injury work?	at	Home 5 Residence 28d. Describe ho		er Specify)
Divisio		Certificate:	2 Accident Investig 3 Suicide 6 Could i 4 Homicide determ	not be		m, street, fac		∕es 2 ∐ No -	28f. Location (St City or Town		er or Rural Route Number,
_	ne Hospit n 24 hour ne Funera pleted fille	Medical	(Check 2 L Medical E	Physician: To the best of r kaminer: On the basis of ex Nurse Practioner: To the b	amination and/or	investigation	ı, in my opinion	, death occurred	at the time, date an	nd place, and due	to the cause(s) and manner stated.
	Voithi Voithi Com		29b. Signature and title of certifier	en st	n		29c. License				(Month, Day, Year)
	2		30. Name and address of person v	/ho completed cause of de	ath (Item 23a) (Ty	Print)	34 A	vál	1100/	3/08	2,06/
	Stat Registra	~	31. Date filed (Month, Day, Year)	32. Registral	's Signature	bar	Kel			-	

 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 Gwendolyn Bowen-Rumber 12:01 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Surburban Hospital Bethesda Montgomery Social Security Number 7, Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 12, 1 □ M 2 🖾 F Months Days Hours Director 578-68-8847 60 1950 Washington DC Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 5721 Grosvenor Lane USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: black If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Lieutenant Kennedy Elementary/Seconday (0-12) College (1-4 or 5+) counselor Institute Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed trent of Health and Mental Hitant: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) Henry Bowen Lois Evelyn Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Cannon Rd; Silver Spring, Maryland 20904 Cheryl Bowen - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 A ther (Specify) cemetery, crematory or other place) Chesapeake Crematory 7/9/10 Beltsville, Md. Maryland Ave. NE Washington, Signature of Furer Uservice Weensee ay lor 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown that the death Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Gwendoiyn ils certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 X No Yes 2 X No To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 🔀 No ၉ Other: 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural (Month, Day, Year) injury 5 Pending Accident 1 🗌 Yes 2 🗌 No after death

Director: A

in by the f Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical *Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D0062435 7/5/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 MOLECULAR DR: ROCKVILLE, MD 20850 SAYED EISAYYAD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEDIN ITEM#20a-c&22perFH, G905, 7/20/2010, WS
State of Maryland / Department of Health and Mental Hygiene

Rumber,

Bauen

10-04679 Staphen Bunk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 21532 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1057 hrs June 21, 2010 'ical Examiner Stephen Bunk c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Dundalk **Baltimore County** 6722 Brentwood Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country)Maryland Months Days Hours Min May 9, 1971 Director 39 1 X M 2 F Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a State 10b County 1 X Yes 2 No Baltimore or 28a-f show MD items 23a or 28a-f shorst be notified at once. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be potified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 USA 6525 Brown Avenue C2 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No 1 Yes Specify: White 1 Yes 2 X No specify: If Yes, Give Year 3 Widowed 4 Divorced 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Flementary/Secondary (0-12) MD 21215-0036 roofing roofer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marlene Theresa Gerver Joseph Frank Bunk Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6722 Brentwood Avenue; Baltimore, Maryland 21222 Sharon Bunk - sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 MOther Specify: in state 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street 21. Signature of e al Service Licensee 1el/An Naylør 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carriac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Heroin intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and cal UNPENDED AMENDED, PII, 27, 28a-f, per ME g906 8/18/10 TT signed by the attending physician I be detached for use as the burial Physician/Medi the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown δ Cocaine use Completed 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of performed? has death? ✓ Yes 2 No 1 🗸 Yes certificate director, page 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA this 2 No 2 1 Yes After the 28a. Date of Injury (Month, Day, Year) 28b, Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred 27. Manner of Death Certification: Fd 1045 hrs 1 Yes 2 No Natural Director: Pending within 24 hours after death. Fd 6/21/10 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State 6722 Brentwood Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State 67 ΜĎ other To the Funeral E (Specify) 4 Homicide 29a. Certifier 1 Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 22, 2010 O.C.M.E. 30. If me and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD.

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ruth Towanda Butler 07 08 - 2010 00:59 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Prince George's Cheverly Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Hours Min 1-03-1956 214-72-4149 53 **Director** Usual Residence of Decedent show 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD Prince George's District Heights 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2124 County Road, #201 20747 U.S. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Black 3 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. 12th Grade College (1-4 or 5+) N/AN/A ulth and Mental Hygis 27 is marked other r traumatic event, ti Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve once. 2 Butler Melvin Young Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2124 County Rd, #201/District Heights, MD 2074 Robert Williams / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Riverdale Park 7-13-2010 Riverdale, MD 4 ☐ Domation 5 ☐ Other (Specify) 22. Name and Address of Facility The House of Williams Funeral Sign dure of Funeral Service Licensee & Cremation Srvcs/4804 Georgia Ave, NW/Wash, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ Malignant Cardiac Arrhythmia) Medical resulting in death) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonary Hypertension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy 1 Yes 2 No ☐ Yes 2 No 25. Was case referred to medical a 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo Hospital: မ 1 Inpatient 2 ER/Outpatient 3X DOA eral Director: After this ifilled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To th best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D66658 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Rexford Babilah, MD

2 2010

31. Date filed (Month, Day, Year)

32. Registrar's Signature

7500 Hanover Pkwy, #101A/Greenbelt, MD 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per 1h g905 7-23-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician 3:03 A M 2010 ೧೪ Mary Agnes Bruno /Medical 4a. Facility Name (If not institution, give street and number, Town, or Location of Death 4c. County of Death Examiner N/A Agnes Baltimore Hospita Social Security Number 220-48-3066 8. Date of Birth (Month, **Des** Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 58 Months Days Hours Min. Director March 3,1952 Baltimore, Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinating must be notified at Maryland Howard Director Elkridge 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6159 River Road Funeral 21075 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify \$ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Material Control Specialist Defense Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry John Sohn Amelia Margaret Vanek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Bruno/ Husband 6159 River Road, Elkridge, Maryland, 21075 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/12/2010 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman FuneralHomeInc. 21. Signature of Funeral Service Licensee 101 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Bilateral Physician Pulmonary Emboli day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Knee Replacement 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 2 No 1 ☐ Yes **Division of Vital** 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 NO 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 24 hours after deatl Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P24063 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Ave. Baltimore, MD 21229 Shannarose Guma 31. Date filed (Month, Day, Year) 32 State Registrar

DHMH 17 Rev 1/2001

RUNO, MARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARICE BROWN 9:08 pM 03 JULY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Ce University Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2**X X**F Months Hours Min. 5-5-1942 Country) 489-46-0494 68 Director Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Howard 1 Yes 2 X No Columbia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6334 Cedar Lane 21044 S Α 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: "natural", 3 Widowed 4 X Divorced Completed Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12th grade **උම්ූ**1්අද Nurse Private Duty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Walker Page 1 and 2 should be Viola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21108 672 Old Mill Road #249 Millerville, MD Johnny Brown-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hollywood Mem Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 7-17-2010 Hollywood, Florida 4 Donation 5 Other (Specify) permit. Signature of Fu al Service Lic. March East F/H 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or a a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): sician and burial-transit Exami or Attending Physician: The law requires that the death certificate be executed Elevat that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) s after death. Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a the Hospital Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JULY 03 1010 P22935 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St N3E09 VICTORIA Baltimore MD 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 1 0 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Paulette Frances Brown 010 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Med Plata La harles If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours Min. 56 095-44-4757 Director August 1,1953 Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Evander in until Not 11 and 20 once. 10b. County 10d. Inside City Limits 10a State 10c, City, Town or Location Director 1XYes 2 □ No Maryland Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 604 Cedar Avenue 20744 United States Funeral 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black ð 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Marriott Hotels 12th grade Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leon . Hudson Brown Hallman Theresa Mae ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcus Jamah Garvin (Son) 1200 Clovis Avenue; Capitol Heights, Maryland 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 26,2010 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Harmony Memorial Park Landover, Maryland 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility R. N. Horton Company Morticians, Dandelsh Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician metastatic disease or condition resulting in death) months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ HepAKKS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2**X** No 1 □ Ýes 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1⊠Yes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 24 hours after deatl Funeral Director: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 00 25 85 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MACLAY MereditH garrett Avenue La Plata MD 20646 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

J

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392

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Karen M. Cassidy Medical Tυ 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1948 1 M 2 1 F Days Director 577-74-2738 61 Sept 26, Virginia Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a, State th the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6000 Bellona Avenue 21212 USA 11. Marital Status unk 12. Was Decedent Ever in U.S. **unk** 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? Race - American Indian, 06/18/10 Armed Forces? 1 Never Married 2 Married 2 white If Yes, Give Year or Dates. 1 ☐ Yes 2 🖾 No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation UN 16b. Kind of Business Industry unit CASSIDY , KAREN M. PT#1024464396 MR#901040754 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ä unk unk ¥ Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) $\, unk \,$ ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 09/26/1948 61 F PILLING, JEFFREY TEAM U (UNITS) Good Samaritan Hospital 5601 Loch Raven Blvd; Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place! 1 Burial 2 Cremation 3 Removal from State 21. Signature of Funeral Service bicensee Nay 1 4 ☐ Donation 5 ☑ Other (Specify) in state 22. Name and Address of Facility Board; 655 W. Baltimore Street Marvland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pulmman disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Garbointerth that initiated events resulting in death) Last D to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ate has been signed by the atte page 2 should be detached for in the past 12 months? Day Pregnant at time of death Unknown Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 HN 1 Tes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital မ 1 Tyes 2 400 Other: 1 Minpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending Accident 1 🔲 Yes M 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 7/2009

within 2 To the

only one)

Pradeep

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 Loch

32. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

RESOUD

Bird, Baltimore MD

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JUN Malter CULVEY Allen 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min (Month, Day,) Director 67 1942 12-40-8714 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director MDHoward Laure1 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? ?7 is marked other than "natural", or items 23a on traumatic event, the Medical Examiner must be Funeral 8751 Boulder Ridge Road 20723 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. <u>ک</u> 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ပ္ Byard Jackson Culver Amanda Mae Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. James Albright/domestic partner 8751 Boulder Ridge Road Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 □ Other (Specify) 21. Signature of Ednéral Service Licensee
Danile A. Waylor 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Pneumon(a disease or condition Medical resulting in death) Examiner severe interstition emphasion and filmsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine pack year tobacco smuking burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) been signed by the attershould be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cancer Records, 1 Yes 2 No 3 Probably 4 Unknown Completed CIERD-gastro egophysen reflux distore 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) mn Jun 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

21538

645

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between

Onset and Death

1 Tes 2 No

unk

Maryland

Year

DHMH 17 Rev 7/2009

State Registrar Howard

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aus

31. Date filed (Month, Day, Year,

		_	For State of Maryland / Department of Health and I State Certificate of Death	Mental I			21539
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. N	o	3. Time of Death
Phys Me	iciar edica		Tanya T. Cleveland	June	22 ^D	2010 Year	7:52 A ^M
Exa		er	4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Med. Ctr. Baltimore	h	40	c. County of Deat N/	
Fune Direct			5. Social Security Number 218-68-9319 6. Sex 1		Birth Day, Year)	9. Bird 1958 M	thplace (State or Foreign untry) aryland
ind show at		۱ ه	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
e Maryla r 28a-f s notified		Sirect Oirect	MD N/A Baltimore 10e. Street and Number 1.0f. Zin Code				1X Yes 2 □ No
h with th		Funeral Director	10e. Street and Number 5002 Barton Avenue 21206		10g. C	itizen of What Co USA	untry?
(and 21215-0036) be filed within 72 hours after death with the Maryland anta Hygiene. ked other than "natural", or items 23a or 28a-f show ce event, the Medical Examiner must be notified at			11. Marital Status 1 Never Married 2XXMarried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Specify Cuban, Mexican, Puerto 1 Yes 2 No	pecify Yes or o Rican, etc.)	No-	14. Race - Ame Black, White Specify: B	
Baltimore, Maryland 21215-0036 semit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam		Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 o	rking	16b. l	Kind of Business	
Iryland A build be filed w d Mental Hygi marked other matic event.		To Be	17. Father's Name (First, Middle, Last) John Robinson 18. Mother's Nam Helen		dle, Maider		
, Maryla id 2 should be salth and Ment n 27 is marke er traumatic			19a. Informant's Name/Relationship (Type, Print) Jerry Cleveland/ Husband 19b. Mailing Address (Street and Number or Ru. 5002 Barton Avenue)	ral Route Nur Balt	nber, City o	r Town, State, Zip Ce, MD	21206
IMOFE, I Page 1 and 2 nent of Healt ant: If item 2			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery 7	Date 7 / 3 / 1 (ocation - City or	
baltimo permit. Page Department Important: If	ouce.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ch. 4210 Belair Roa	natmar ad Bal	n-Har Ltimo	ris Fu re, MD	neral Home 21206
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final	or respirator	y arrest,		Approximate Interval Between Onset and Death
Priysicia Medic Examir	cal		disease or condition resulting in death) a. Due to (or as a consequence of):				
A Z E		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury				
te be executed hysician and he burial-transi		al Exal	resulting in death) Last C. Due to (or as a consequence of):				
(b)	1	ledical	d				
DIVISION Of VITAIL RECORDS, P.O. BOX 08 /000 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Ectopic pregnancy 1 Ectopic pregnancy 1 Pregnant at time of death 5 Other (specify) 1 Other (s			23d. Date of de Month	livery Day Year
IS, P.O. Lires that the signed by lid be detac	 - -	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		id tobacco		the cause of death?
VITAI KECOTGS, ysician: The law requires is certificate has been sig	,	Completed		a	Vas an autopsy performed? Ves 2 L	prior to	topsy findings available completion of cause of
cian: T			25. Was case referred to medical examiner?		res ZLVI	10 10	S Z LINO
TVIII Physic this co		2	1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA Other: 4 ☐ Nursing H	T		6 Other (Spec	ify)
On O anding I sath. ir: After		Certificate:	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation M 1 Yes 2 No	28d. Descri	be how inju	ry occurred	
DIVISION Or all or Attending It is after death. In Director; After ed in by the funer			3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		on (Street a Town, State		ral Route Number,
DIVISION OF VITAL MEDICAL TO THE HOSPITAL OF A THE MEDICAL THE WITHIN 24 hours after clearly. To the Funeral Director, After this certificate completed filled in by the funeral director, pag	:	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a complete only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a complete only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, a complete only one)	at the time, da	ate and plac	e, and due to the	cause(s) and manner stated.
To t with			29b. Signature and title of certifier mo 29c. License number D34146		29d. D	ate signed (Montl	n, Day, Year)
g			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NUTUM West 3120 Erdman Avence Buttinge	March	Lnal	2121	2
Regi	State stra		31. Date filed (Month, Day, Year) (32. Registrar's highard)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 21540 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 07-02-2010 Year Elmo St. Clair 0415pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore City 537 Benninghaus Rd If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F 19 35 North Carolina Director 74 244-48-4333 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County Director 10c, City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 537 Benninghaus Road 21212 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces?

1 Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha years Safety Manager <u>Vallev Proteins</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hughey Alexander St. Clair Ann Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tisha St. Clair/ Daughter 5305 Wyndholme Cir.#203 Balto. Md 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o Department of 1 Burial 2 Feremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/09/2010 Greenmount Cem. Balto. Md 21. Signature of Faneral Service Licenses 22. Name and Address of Facility Balto. Md Rd. 21206 Chatman-Harris F.H. 4210 Belair 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Deat Ph sician/ months Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Adenoma Tubular 1 Tes 2 No 3 Probably 4 Unknown Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Degenerative Arthritis performed? Yes 2 No within 24 hours after death.

To the Funeral Director, After this certificate it completed filled in by the funeral director, page Knee 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital⁻ Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29c. License number D 34851 MA

Registrar
DHMH 17 Rev 7/2009

State

RMB 500

5601

Loch Raven Blvd

21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

		Please	Type or Prin	t in I	Black Ir	ndelib	le Ink	. Ensure	All Co	oies A	re Leg	ible.		
	•	For State Registrar	State of Ma	rylar	•			Health and <i>Death</i>	d Menta		ene 20	10	21	54
Physicia		Decedent's Name (First, Middle, La RANDY HOWARD C	•						Mor	of Death	Day	Year	3. Time 7:30	of Death
/Medica Examine		4a. Facility Name (If not institution, gi					y, Town, o	or Location of De				y of Death		
Funeral Director		217 00 3313	Sex 7. Age	51	last birthday Yrs.	Month	er 1 Year s Days		ns. 8. Date in. (Mo. NOV.	of Birth orth, Day, Y 20,	^(ear) 1958	Coui	olace (Stat ntry) YLANI	te or Foreig
with the Maryland a or 28a-f show	ō	Usual Residence of Decedent 10a. State 10b. County MD • N/A			ty, Town or L							1		City Limits
h the h	irect	10e. Street and Number		DP	TTTTIO		Zip Code			10g	j. Citizen of	What Cour	ntry?	
ath wit	la	442 ELRINO STREE						1224			ITED	STATE	S	
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, it is Medical Examiner mast be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	er in U	I.S. 13.		edent of pecify Cub 2 XNo	Hispanic Origin? pan, Mexican, Pu Specify:	(Specify Yes erto Rican, e	s or No- tc.)		ice - Americ ack, White, fy: WH		
nd 2 should be filed within 72 hours a aith and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, It a Medical Exert	Completed	15. Decedent's E (Specify only highest gr	ade completed) College (1-4or 5	+)		e kind of v DO NOT	vork done use retire	during most of wed)			b. Kind of E		·	
d be filed w ental Hygie ked other t c event, Ib	o Be Co	12TH 17. Father's Name (First, Middle, Last JOHN CASHION	•		MAIN	LENAN	CE S	UPERVISO 18. Mother's N DORIS	lame (First,		BALTI iden Surna		CTTY	
permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 Is marked any injury or other traumatic er once.	ှင်	19a. Informant's Name/Relationship CINDY CASHION/WI				-		t and Number or	Rural Route	Number, C		n, State, Zip 212		
of Head of Head of Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Domoval from State	20b.	Place of Disp cemetery, cre	osition (N	ame of r other pla	ace)	Date	20	c. Location	- City or To	wn, State	
t. Pag rtment rtant: I		4 ☐ Donation 5 ☐ Other (Speci	fy)	AT	LANTIC				10/20					
permi Depar Impor any ir		21. Signature of Funeral Service Lice	nsee					ess of Facility C					-	.NG. .224
Physician /Medical		23a. P 11. Enter the dis sed or on shoot, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each lin a. Due to (or as a	e. Nel	th. Do not er								Approxim Interval E Onset an	nate Between
e be executed sician and purial-transit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as a		-/	er								
be icia	edical E		d											
ath cer ttendin or use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗆 Feta	al death 3	□ Ectopio □ Other		су				ate of deliv	ery Day	Year
quires that the de	d by Pr	Part II. Other significant conditions	contributing to death bu	t not res	sulting in the	underlying	ı cause gi	ven in Part I.	236	e. Did toba	cco use cor 2√2 No			of death? ☐ Unknowr
The law require ate has been si bage 2 should to	Completed								_	a. Was an autopsy performe		. Were auto prior to co death? 1 ☐ Yes	mpletion o	gs available of cause of
iclan: Sertifica Setor, p	e Re	25. Was case referred to medical examiner?						26. Place of D			10 1	13.00		_
Physic ruthis or ral dire	<u> </u>	1 ☐ Yes 2 ANo 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatie		DOA Ot		Home 5		ce 6 O		<i>fy)</i>	
Attending death. ctor: After y the fune	Certification:	1 Matural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be	(Month, Day	(Year)	Injury	М	1 C	rk?]Yes 2 □No			et and Num		al Route N	lumber
tal or /	Certi	4 ☐ Homicide determined	building, etc	. (Speci	fy)	,	. ,, 011100		City	or Town,	State)	or right		
To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examin	owledge, dea ation and/or i	th occurrenvestigati	ed at the toon, in my	time, date and pla opinion, death o	ace, and due	to the cau e time, date	use(s) and r e and place	manner as : e, and due t	stated. o the caus	e(s)
To the Com	Σ	29b. Signature and title of certifier				2	9c. Licen	se number		290	d. Date sign	ed (Month,	Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MINUS VASILIADET. 9000 Franklin Sq. Drive Baltimore, MS 21237

31. Date filed (Month, Day, Year) 32. Registrar's Signature

DOOG4755

7/4/2010

VASILLADES, M.J.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g905 7-21-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) Shirley Elizabeth Collins 2. Date of Death Physician/ Day olling 1:20 AM 2010 July Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITA N/A Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Hours Min. Sept. 5, 1935 74 Maryland Yrs. Director 216-32-±844 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified South Baltimore Maryland N/A 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21230 134 Fast Gittings Street ural", or items 2 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Specify: "natural" Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working r than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the hay injury or other traumatic event. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Schultz Charles Detress 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Fast Gittings Street, Baltimore, Maryland 21230 Albert F. Collins Jr (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 14, 2010 Meadowridge Mem. Park Elkridge, Maryland 21. Signature of a fall Service Licen. 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nediate Cause (Final Metastatic Onset and Death CUTANEOUS Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be to a few hours after death.
I 24 hours after death.
E Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 l 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypoventilation SYNDROME 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s 2 X No 1 ☐ Yes 2 🔀 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🔲 Yes 2 No မ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) July 9, 2010 RES000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 3001 South HANOVER Street, BALTIMORE, MD Luke J. Higgins

DHMH 17 Rev 7/2009

State Registrar 32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July Edna Ellen Duva11 04, 2010 7:20 A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7835 Jessup Road Howard Jessup 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F Months Days Hours 02-01-1918 **Director** 213-16-0872 92 MD Usual Residence of Decedent 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

The strain and Mental Hygiene with a trians "natural", or items £3a or £8a-f show item 2.7 is marked other than "natural", or items £3a or £8a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No MD Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7835 Jessup Road 20794 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ٩ John George Rose Emma Gertrude Chesser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Toni Rose- niece 7835 Jessup Road, Jessup, Maryland 20794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Prk. | 07-08-2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of uneral \$ MMP., Inc., 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: es, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Dav Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 3 Probably 4 Unknown Completed No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar RIVA MICK Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Juliy 8, 2010 Patricia Judge Douglas 8:45 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 628 Debaugh Ave. Towson 8. Date of Birth (Month, Day, Year) Dec. 16. 1924 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Director 214-20-5950 85 Maryland Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 628 Debaugh Avenue U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Be Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 🕅 Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Card & Gift Shop Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Leahy Judge Florence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10525 York Avenue Richard C. Douglas Cockeysville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
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1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ₺ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy completed filled in by the funeral director, page 2 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Hospital ျှ 1 🔲 Yes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one 29b. Signature applitle of certifie 29c. License number 29d, Date signed (Month, Dav. Year) 12 ss of person who completed cause of death (Item 23a) (Type, Print) 7600 Osler Dr. #311 Towson, Md. 21204 .MD

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 2 0 1 0

	•	State Registrar			Certificate of L		viorital riy	Reg. N	2010) 215	046
Physicia	n/	1. Decedent's Name (First, Middle, Last Antiono Engli					2. Date of De _Month		ay Year	3. Time of D	
Medic	al	4a. Facility Name (if not institution, gives			4h City Town o	r Location of Death	July		^{ay} 2010		1 M
Examin	er	Stella Maris H			rimoniu				c. County of Dear		
Funeral Director		5. Social Security Number 6. Sec. 218-02-2679		st birthd Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin Month, Da 1 / 3 / 8 3		9. Bir Co MD	thplace (State or I untry)	Foreign
nd how	ž	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town o	r Location					10d. Inside City	Limits
/aryla 8a-f s tified	Director	MD N/A	É	Balt	r Location imore					1 ☐ Yes 2	
with the N 23a or 2 ust be no	Funeral Di	10e. Street and Number 704 E. 41st Sti	reet	_	10f. Zip Code 21218	 3	Ī	-	itizen of What Co	ountry?	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Fun	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Year or Dates.	i.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Africa Specifamer	e, etc. n	
1215-C hin 72 hou ne. than "natu te Medica	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		(G	ecedent's Usual Occup live kind of work done c e. DO NOT use retired) borer	ation during most of work	king		Kind of Business	*	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exami	as l	12 17. Father's Name (First, Middle, Last) Richard English	1		BOTCI	18. Mother's Nam Brenda			Surname)		
Mary d 2 should alth and M 27 is mar er traumati		19a. Informant's Name/Relationship (Typ. Rudrigo Mathuri	pe, Print) In/Uncle		Mailing Address (Street a				r Town, State, Zij	o Code)	
imore, Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		motory	isposition (Name of crematory or other place w Crematory	ory 7/15	Date 5 / 1 0		ocation - City or	Town, State	
Balt permit Depart Import any inj		21. Signature of Fune al Service License			22. Name and Addres	ss of FacilityHar air Rd,E	i P. C Balt.,M	llos ID 2	se F.Sv 21206-5	7s,PA 5105	
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ications that caused the death e cause on each line. a. Due to (or as a consequ			g, such as cardiac	or respiratory an	rest,		Approximate Interval Betwe Onset and De	
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8760 tiflicate be ng physic as the bu	Medical	IF FEMALE:									
OX 6 ath cerl attendii	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у			23d. Date of del Month	livery Day Yea	ar
gned game	þ	Part II. Other significant conditions cor	ntributing to death but not resu	ilting in ti	he underlying cause giv	en in Part I.	23e. Did to		V	the cause of dear	
CC law	Completed							rmeo?	prior to death?	topsy findings ava completion of cau	
Vital F ysician: T is certifica director, p		25. Was case referred to medical examiner?				ace of Death (Chec	1 ∐ Yes k only one)	2 14	10 10 105	2 110	
Physic this c	은 .	1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ I 28a. Date of injury	ER/Outpa		4 ∐ Nursing Ho			6 Other (Spec	ity top	re
ION O eath. or: After the funer	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	inju	y work	Yes 2 No	28d. Describe h	ow inju	ry occurred		
DIVISION OF ital or Attending Phus after death. The start of the star	_	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Tow	n, State	e) 	ral Route Number,	
Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completed filled in by the funeral director, page	Wed	(Check 2 Medical Examine	cian: To the best of my knowle er: On the basis of examination Practioner: To the best of my	and/or in	vestigation, in my opinio ge, death occurred at the	n, death occurred a time, date and place	t the time, date a ce, and due to the	nd place e cause(e, and due to the o s) and manner as	cause(s) and mann stated.	er stated.
5 ≥ 5 8		A LANCE OF GETTINET	CRNP		29c. License	9792		29d. Da	te signed (Month	1 12	
2		30. Name and address of person who co	mpleted cause of death (Item CANP 23	23a) (Typ	Dulane.	Valley	Rd. Ti	m it	N I I I Am	MD 212	93
State Registra	-	31. Date filed (Month, Day, Year)	32. Redistrar s Signatu	J.	ball		,		······································		

		1 - For State Of Warying Registrar	-	tificate of Deat				2010	21547
Physic		1. Decedent's Name (First, Middle, Last) Joseph John Etzel	, Jr.			2. Date of De		.0 Year	3. Time of Death 11:15 p M
Exam	dical iner	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Locat	tion of Death		4c. Co	ounty of Death Baltimo	
Funera			s. last birthday)	Towson If Under 1 Year If Under 1 Year Hou	nder 24 Hrs. urs Min.	8. Date of Birt	th Valent 2.0	9. Birth	place (State or Foreign
Directo	or	213-30-0727 1 X M 2 L F 7 Usual Residence of Decedent	/ Yrs.	Noneria Baya Prod	u	0ect ^{nt} 27ª	7 1932	Mary	ľánd
aryland a-f shor	Director	10a. State 10b. County 10c. MD Baltimore	City, Town or Loc					1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
a or 28 be noti				10f. Zip Code				n of What Cour	
eath with	Funeral	211 Ridge Avenue 11. Marital Status 12. Was Decedent Ever in	U.S. 13. V	21286 Vas Decedent of Hispanic	c Origin? (Spec	cify Yes or No-		J.S.A.	an Indian
ITE, MISTYIGITU Z LZ ID-UUJO 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	۵	1 Never Married 2 X Married 1 X Yes 2 No	1	Vas Decedent of Hispanic Yes, specify Cuban, Mex Yes 2 X No Spe		Rican, etc.)		Black, White,	etc.
72 hou	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	ent's Usual Occupation ind of work done during i DNOT use retired)	most of workin	g	16b. Kind	of Business Inc	dustry
d withir dygiene the the the	Be Co		Los	ss Preventio				Insuran	ce
d be file Mental H arked o	12		Sr.	18. N	Mary Mary	(First, Middle,		Schwi	ndel
Mith and I		19a. Informant's Name/Relationship (Type, Print) Marian E. Etzel-wife		g Address (Street and Nu Ridge Ave.,			r, City or To	wn, State, Zip (Code)
permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 2		20a. Method of Disposition 1 Removal from State P P 20b. 20c. 2	o. Place of Dispos		1	ate		tion - City or To	
parmit. Page 1 Department of Important: If it any injury or o	5	21. Signature of Funeral Service Licensee William G.		Name and Address of Fa					ome, Inc.
Physician		Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	eath. Do not ente		h as cardiac or				Approximate interval Between Onset and Death
Medica Examine		resulting in death) Due to (or as a conse							
, p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	equence of):						
cate be executed physician and the burial-transit	Exar	Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as a conse	equence of):						
gate be	edica	d							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 23c. If yes, outcome of pregnant at time of pregnant a	etal death 3	Ectopic pregnancy Other (specify)			230	d. Date of delive	ery Day Year
that the	by Ph	Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause given in F	Part I.	23e. Did to	bacco use	contribute to th	e cause of death?
requires	eted	-							pably 4 🗆 Unknown
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Attendii r death. ctor: Ai	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		M 1 Tes 2		8f Location (S	treet and N	umber or Rural	Route Number
oital or Jurs after	al Ce	building, etc. (Spec	cify)		Į.	City or Tow	n, State)		
he Hosp in 24 ho he Fune pleted f	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my known control of the best of certifying Physician: To the best of my known control of the best of the	tion and/or investi	gation, in my opinion, deat	th occurred at t	he time, date a	nd place, an	d due to the cau	ise(s) and manner stated.
To the contract of the contrac		29b. Signature and title of certifier		29c. License numb				igned (Month, L	
1141		30. Name and address of person who completed cause of death (It	em 23a) (Type, Pr	int) N Cha	arles	97	cme	192	0
St Regist	ate	31. Date filed (Month, Day Year) 32. Registrar's Sig		-					

10-04849				or Print in B						egible) .	
Keith Lamont Fl			Stat	e of Maryland				nd Menta	l Hygiene		201	0 2151
		1- For State Registrar			Cer	tificate c	of Death			Reg. No.		
Physicia		1. Decedent's Nam			5 3.4.	1			2. Date of De Month	eath Day	Year	3. Time of Death
Medical Exami	ner	Keith			Fleto	ner			June 28,			1025 hrs
			(if not institution, o rge's Hospita	give street and number	r)		4b. City, Town, Cheverly	or Location of L	Death		County of Deat Prince George	
			· .		// 1-	-4 3 5-414 3			Miles To Date of F			
Funeral Director		5. Social Security I			ge (In yrs. la	st birthday)	If Under 1 Y	ear If Under 2 ays Hours	Min		Forei	thplace (State or Wash,
Director		578-21-	1010	XM 2 F	20	Yr	S.		11-	7–19	89 c	D.C.
è		Usual Residence of	of Decedent 10b. County		Inc City	Town or Loca	ation				_	10d. Inside City Limits
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ath w	Funeral	1 X Never Marri	ied 2 Marri	ed Armed Forces	?				? (Specity Yes or Nuerto Rican, etc.)	10-	White, etc.	ican Indian, Black,
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irs afi tural'	9			or Dates: only highest grade co	mpleted)	16a. Decede	nt's Usual Occup		d of work done		(ind of Business/	
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		Sabrina		er / Mot	her				Oxon Hi			
s l ar s l ar of Hee If ite		20a. Method of Dis	<u>·</u>	Removal from S		lace of Dispo ematory or o	sition (Name of on the control of th	cemetery,	Date	20c. L	_ocation - City or	Town, State
Page nent c		_	Other Speci	_		cmony	Memori	ial	7-1-10	Ну	attsvi	lle, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Ī	21. Signature of Fu	ineral Service Lic	ensee		22.	Name and Addre	ss of Facility	Univer	sal	Mortua	ry Inc.
00 8 A A .E		1 del	y Iv	artin		4	11 Kenr	nedy S	t, NW, N	Wash	ington	, DC 200
Physician /M. i I		23a. Part I. Enter the failure. List on	ne disease, or cor nly one cause on	nplications that cause each line.	d the death.	Do not enter	the mode of dyin	g, such as card	iac or respiratory a	rrest, sho	ck, or heart	Approximate Interva Between Onset and
Examiner		Immediate Cause ((Final disease	_{a.} Multiple Gunsh	ot Wound	ds						Death
	- 1	or condition resulti	ng in death)	Due to (or as a cons	sequence of)	:						
	ᡖ	Sequentially list co		b Due to (or as a cons	sequence of)							-
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3760, ficate be of g physicia s the bunia	Š.	IF FEMALE: 23b. Was decedent	pregnant in the	23c. If yes, outco	me of pregn		etal death 3	Ectopic pre	onnanav	1 1	I. Date of delivery Month	/ Day Year
Sox 687 leath certific e attending p for use as th	Physician/Med	past 12 months	5?		t time of dea	·h - =	etal death 3 ther (Specify)		egnancy		WORLD	Jay Tear
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buin		Part II. Other signi	ificant conditions	contributing to dea	th but not res	sulting in the	underlying cause	given in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
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Division of Vital Records, tal or Attending Physician: The law require is after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	m	examiner?	2 No	Hospital: 1 Inpati	ent 2 🗸 E	R/Outpatien		Other:	ursing Home 5	Resider	nce 6 Other	
of \ ing Phy After th	유	27. Manner of Deat		28a. Date of Inj	ury	28b. Time of		jury at Work?	28d. Describe	how inju	ry occurred	
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IVISIO	ig.	2 Accident 3 Suicide	Investiga 6 Could no	20a Diago of I	njury - At hor	ne, farm, stre	et, factory, office	building, etc.	28f. Location	(Street ar	nd Number or Ru	ral Route Number, City
Div	Certification:	3 ☐ Suicide 4 ✓ Homicide	determin		ulti-Family	Apt.			or Town, 4403 Rena F	State) Road Apt	t 103 , Forestv	ille , MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1	Certifying Physi	cian: To the best of n	ny knowledge	e, death occu	rred at the time,	date and place,	and due to the cau	ıse(s) and	d manner as state	ed.
To the Howithin 24 h To the Fur	Medical		Medical Examin	er: On the basis of exa and manner stated	mination and	d/or investiga	tion, in my opinio	on, death occum	red at the time, date	e and plac	ce, and due to th	e cause(s)
F.3 F. 8	Me	29b. Signature and	title of certifier				29c. Licer	nse number		29d. D	Date signed (Mo.	nth, Day, Year)
		D.	\bigcap	Foller			0.0	M.E.		June	29, 2010	
	ŀ	30. Name and addr	ess of person who	completed cause of	death (Item 2	?3a)					-	
2			nica-Pollak M			,	111 Penn S	Street, Baltir	more, MD 2120	01		
St	ate	31. Date filed (Mont	th. Dav.Year)	32. Registra	ar's Signatu	9 4						

OCME

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jane Marie Folev For Ju₁y 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 6409 Koffel Court **Elkridge** Howard Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 K F 053-20-0379 83 09-20-1926 New York Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f showing the Modical Examiner must be notified at 1 ☐ Yes 2 TXNo Director Elkridge Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6409 Koffel Court United States death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after (Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Ideath or other traumatic event, the Ideath or other traumatic event, the Ideath or item once. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married Married 1∐Yes 2∏xNo Specify 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret P. Connelly ပ John William Coogan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph S. Foley - spouse 6409 Koffel Court, Elkridge, MD 21075 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8-18-10 Arlington National Arlington, Virginia 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service MMP., Inc., 7250 Wash Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
8 //z hau/s Immediate Cause (Final erebral Vascolar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to him date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending PhysIclan: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Rheumatoid Arthritis 24b. Were autopsy findings available prior to completion of cause of death? Obstructive Polmonary performe Disease 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 → Residence 6 ☐ Other (Specify) 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation n 24 hours after death. le Funeral Director: Aft pletely filled in by the fun 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🛄 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 053966 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kristin Clark, MD, 5018 Dorsey Hall Drive, Suite 104, Ellicott City, MD 21042 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month_ Edward Fogel 32PM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death oastal Hospice a14 Salis wico-micto 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** July 17, Year 1912 1 X M 2 - F Days Hours Min. Pennsylvania Director 160-09-2360 97 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director MD Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5864 Airport Road 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ Black, White, etc 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or 1 Yes If Yes, Give Maryland 21215-0036 white 1 ☐ Yes 2 K No Specify: 3 XWidowed 4 ☐ Divorced Specify Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 master plumber construction Be 17. Father's Name (First, Middle, Last)unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is Robert Fogel - son 7341 E. Vuelta Rancho Mesquite; Tucson, AZ 85715 injury or other Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 🖾 Donation 5 🖵 Other (Specify) 21. Signature of Fund Parvice Lifensee Nay1 Bal 22. STate Affatomy Board; 655 West Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jan Priysiciani disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an Were autopsy findings available prior to completion of cause of CHACER page 2 autopsy death? certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ဂ 1 ☐ Yes 2 🔀 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) HOSPice 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work? Accident Investigation 2 No 24 hours after dea Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 07-05-2010 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M, BELLOSO M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 State 32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical nstitution, give street and number Town, or Location of Death Examiner 4c. County of Death ISA WISING pme timore Age (In yrs, last birthday)

Out Yrs. 8, Date of Birth Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 😿 F Director 28a-f shov 10b. County aţ 10a, State City, Town or Location 10d. Inside City Limits Director Examiner must be notified 4T timore 1 Yes 2 No ō 10f, Zip Code 10g. Citizen of What Country? 21206 23a Funeral items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, ò ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumost. College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid ၉ moor Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) QUSIN Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service icensee MOISS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between EMENTIA Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy perform 1 Yes Division of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this . Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After work? 1 ☐ Yes 2 ☐ No Natural 5 Pending injury 24 hours after death. Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only on the 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name a

31. Date filed (Month, Day,

pleted cause of death (Item 23a)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 10 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>010</u> Physician/ Month July Melvin John Goetzinger 3:05 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Middle River Woodlands Assisted Living 8. Date of Birth (Month, Day, Year Sept. 29 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 X M 2 - F Maryland 216-09-7824 Director 91 Usual Residence of Decedent 28a-f shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Glen Arm 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21057 U.S.A. 4037 Holly Knoll Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item Z7 Is marked other than "natural", or any injury or other traumatic event, the Medical Examina pones. Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5 yr's Self Employed HVAC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Goetzinger Mollie Cole Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4037 Holly Knoll Drive Glen Arm, MD 21057 Mr. Gary A. Goetzinger - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State July 12, 2010 Middle River, MD Holly Hill Cemetery! 4 Donation 5 X Other (Specify) Entembrent . Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Maryland 21214 <u>5305 Harford Rd</u> <u>eonard J. Ruck.</u> Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final diac Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Kuown Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 1 ☐ Yes 2 ₹ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 2 No 1 Yes ☐ Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Hother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After topleted filled in by the funeral 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complete only one) 29b. Signature and title of certifier MD 07-08-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malika Waseem, M.D. 709 Eastern Blvd 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

se Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 9 per ab g905 7-14-10 vt

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#20a-cs22perFH.G905.7/20/10

Certificate of Death

Reg. N2 0 1 0 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Andrew W. Hardina DLO 825PM മാശ /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 24505 siloan Rd. Salisbun wicomico Soll Shury,
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Sex 1. M 2□ F Year) Days Hours 216-88-641 Director 1964 Washington, DC. 0102 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show if than "natural", or items 23a or 28a-f show the Medical Experimental be notified at Director 1 ☐ Yes 2 🛣 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26505 Siloam Road Funeral 21801 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Specify: white Baltimore, Maryland 21215-0036 \$ If Yes. Give 1 ☐ Yes 2 🖾 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) construction laborer is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill sht of Health and Mental Ht: If item 27 is marked oth Be Doris Carolyn Smythe Wilbur Andrew Harding ౖ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Harding - sister 26505 Siloam Road; Salisbury, Maryland 21801 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriat 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖼 ether (Specify) in state Final Journey 7/10/10 Woodbine, MD 21. Signature of Fune al Service/Licensee Danie JA. Nay lor 22. Name and Address of Facility Charisse N. Woods By Smore 2700 Edwordson Avend Baltyimore, MD 21223 Cb 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Esophand **Physician** Metastatii /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Due to (or as a consequence of) Box 68760, that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I ☐Yes 2☐No been signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown Completed Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Vital 1 ☐ Yes 1 🗆 Yes the Hospital or Attending Physician: npletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of Director; After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 2 Accident investigation M 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funeral Direct determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Dosta 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

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amend item 26 per dvr g905 7-12-10 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 09^{Day} Physician/ JULY 2010 9:13 A M **JEROME** HART Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 2921 WOODVALLEY DRIVE BALTIMORE 6. Sex 1 ☐ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 05/05/1930 Country) MD Director 215-30-9129 80 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 1 ☐ Yes 2 🙀 No PALM BEACH PALM BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3546 SOUTH OCEAN BLVD., APT. 704 33480 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 ☐X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TEXTILES RETAILER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HART FLORENCE SNYDER RAYMOND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2921 WOODVALLEY DRIVE, BALTIMORE, MD 21208 ELLEN HART/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM. 7/11/2010 REISTERSTOWN, MD Donation 5 Other (Specify) 22. Name and Address of Facility Sic atule of Fulleral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metestatic Physician/ disease or condition resulting in death) Morths colencorcione Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): for use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burlal. Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown diebetes nellito 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? After this certificate has page 2 performed ☐ Yes 2☐ No 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner?

1 Yes 2 No Znd Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 6 X Other (Specify) Residence မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0020604 ichard a Berg 40 7/9/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Berg, 40 #450, 10755 Folls Rd, Lutherville, hd 21093 31. Date filed (Month, Day, Year) JUL 1220 istrar's Signature State Registrar

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		101 W. 22nd Street	6.000	T7 Ago (In ugo)	lost hidhday)	Baltim If Under		If Under 2	24Hrs	8. Date of Bi	rth/MM/F	<u> </u>	Q Rint	nplace (Sta	ate or
Funeral Director		5. Social Security Number 220 – 80 – 1061	6. Sex	7. Age (In yrs. I	Yrs.	Months		Hours	Min.	10/9	•		Casalas		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Location	on								10d. Insid	e City Limits
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1		30. Name and address of person	1 who completed cau	ase of death (Iter	n 23a)		O.C.M	1. ►.			July	10, 20			
6		Carol Allan, MD As	sistant Medical	Examiner	111 Penn S	Street, E	Baltimo	re, MD 2	21201						
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DHMH 17 Rev 1/2001

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2+12		 Name and address Zabiullah Ali, 	,		pleted cause nt Medica				n Street,	Baltir	more, M	ID 2120	1					
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Amend Item 23aPtI, II, per me , g905,07/14/2010dhb
Amend Item 29d per dr., g905,07/14/2010dh 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear Ha llums **Physician** Judith 10: 22 GM W /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) altimore Examiner vorth 8. Date of Birth Month, Day, Year 39 Birthplace (State or Foreign Country) If Under 1 Year Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗷 F Months Days Hours Min. MI Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 9 Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗹 No Saltimore, Maryland 21215-0036 Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. is marked other than Child Childcare 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOK 2 grave 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Prindle 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 21015 DateUNK 3 ☐Removal from State 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Licens 22. Name and Address 1232 Midvalley Dr. Jessup Approximate Interval Between Onset and Death Due to (or as a conjequence of): **Physician** /Medical Examiner Gadhic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ON APPROVED BY NEDICAL EXAMINER Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): physician CERTIFIC use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown signed by tl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by trbollation 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes = 2 □ No Hypertension 24a. Was an autopsy page NUSANGGIA, Gastric Mass 2 No certificate Physician: 25. Was case referred to me examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 27. Manner of Math 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury To the Hospital or Attending 1 Natural 2 Accident To the Hospium:
within 24 hours after death.
To the Funeral Director: A' 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 16, 2010 60064267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 lenden AV Baltiro 21201 Cean & Bioco 31. Date filed (Month, Day, Year) State 07 Registrar

		1	For Amend Item 2	26 State of Ma per ver	aryland	905,00 Ce	7/12/2016 ertificate of l	lealth and dhb Death	d Mental Hy	giene Reg. N	2010	215	558
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336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	P S	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			. Was Decedent of H If Yes, specify Cub.		erto Rican, etc.)		Black, White, of Specify: Bla	etc.	
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	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or com, shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	nications that caused ne cause on each line a. Due to (or as	e. 0 ba	ble	cardia		liac or respiratory and the high the modern of the modern	-		Approxima Interval Ber Onset and	tween
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# 2/ Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 🗌 Feta	al death 3	☐ Ectopic pregnar	ncy			23d. Date of deliv Month	-	Year
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	To the Hospital or Attend within 24 hours after deati To the Funeral Director: completed filled in by the	Medical	(Charle 2 Modical Evan	sician: To the best of iner: On the basis of se Practioner: To the	ovaminatio	n and/or inv	estigation, in my opir e, death occurred at	nion, death occur the time, date an	red at the time, date d place, and due to t	and pla he caus	se(s) and due to the case(s) and manner as s	tated.	lanner stated
	North Voith Com		29b. Signature and title of certifier	ke mos				0 5 8 3	309		Date signed (Month,		
	4		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type	e, Print)						

State Registrar

31. Date filed (Month, Day, Year) **31. 1. 2.2010**

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 2-010 9.35 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE BACTMORE WASHINGTON MEDICAL Airundec EN 151 Social Security Number 6. Sex 8. Date of Birth
Dec 31, 193 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 215-28-6370 1 X M 2 🗆 F Pennsylvania Director 78 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore Maryland 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4024 Eighth Street 21225 IISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dye Maker Eastfield of Baltimore Be 18. Mother's Name (First, Middle, Maiden Surname) Anna Mae Coleman 17. Father's Name (First, Middle, Last) 2 Chester Leroy Houtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Rainwater Way #102 Glen Burnie, Maryland 21060 Dale Houtz (Brother) 20a. Method of Disposition Hour 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 7/12/19 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Fune al Service Licensee Kevin E Ecker 237 E. Patapsco Ave., Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner AC DUP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 physicians the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed been si should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to completion death? autopsy performed Yes 2 this certificate has page 2 1 Yes 2 🗹 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Mann of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 / Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: A 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Nurse Pranticion. To the best of my knowledge, death occurred at the time, date and place, and due to the national time are stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d_Date signed (Month, Day, Year) シスト Name and address of person who complet d cause of death (Item 23a) (Type, Print) ENLY 18BA 400 Date filed (Month, Day, Registr s Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh g905 7-14-10 vt
State of Maryland / Department of Health and Mental Hygiene 21560 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ enno Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death tarford 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 F Days Months Hours Min (Month, Day, Ye Mary land Director -10-104 Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits e filed within 72 hours after death with the Maryland 10c. City, Town or Location event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No taxford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 ☑ Widowed 4 ☐ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should e filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is mar ed other than any injury or other traumer: Elementary/Seconday (0-12) College (1-4 or 5+) 1 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roc Trendu 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date UNK 1 Barial 2 Cremation 3 Removal from State cemetery, cremators 4 Donation 5 Other (Specify) 21. Signature of Paneral Service License 22. Name and Address of Facility Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re r heart failure. List only one cause on each line. 23a. Part 1 shock Approximate Interval Between Immedia Cause (Final Onset and Death Physician/ disease or condition A Cavall Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ signed by the atte in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Yes 2 No 1 Yes 2 No or Attending Physician; completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 **N**o Other: 1 Yes ASSITAN 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at LIVIN 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State the Hospital within 24 hours a Medical 1 Cycertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) d address of person who completed cause of death (Item 23a) (Type, Print aml 6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MILOS JANSA 2010 07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Montgomery Manor Care Potomac Potomac 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours Min. 1 4 M 2 F Director 089-30-0104 Czechoslovakia Yrs Usual Residence of Deceden 28a-f shov 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Prince Georges Landover Hills 10e, Street and Number ក 10g. Citizen of What Country? 9.75854 Funeral with 23a 7403 Varnum Street United States items ? 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian Armed Forces? 1XXX Yes 2 \(\sum_{No} 1951 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married "natural", or Completed by Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 KNWidowed 4 Divorced 1958 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 Ph n and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Physician Pediatrics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vlasta Kalous Rudo1ph Jansa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a Marianne H. Jansa - daughter 1955 Pometacom Drive, Hanover, Maryland 21076 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or 4 Donation 5 Other (Specify) Meadowridge Mem. Pk. 07010-2010 | Elkridge, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at any MMP., Inc. 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Lung Physician/ disease or condition resulting in death) Medical Due to (or as a onsequence of): Examiner AILYRE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 attending p IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy perform 2 🗌 No Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Universing Home 5 - Residence 6 - Other (Specify) 2 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 🔲 Yes 2 🗆 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, or Attending Physician: Hospital

To the I

State

Registrar

Medical

29a. Certifier

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pinky Singh, MD, 10714 Potomac Tennis Lane. Potomac, MD 20854

31. Date filed (Month, Day, Year)

Fortifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00057458

29d. Date signed (Month, Day, Year,

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death A 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0549 M **Physician** JULY 2010 Doresa Annalee Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Esther Place Balto If Under 1 Year 5. Social Security Number ear | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 🕱 F 60 217-56-5117 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show event, the Medical Examiner must be notified at **Funeral Director** Baltimore Yes 2 □ No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 Items 23a 21213 USA 1834 E. Lafayette Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 **K** No 14. Bace - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any Injury or other traumatic event. Black, White, etc. 1 ☐ Yes 2 **X** If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 □Yes **X**□XNo Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working unk life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
9th grade College (1-4or 5+) Abacus 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel M. Woodlock Alphonso Mitchell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1702 E. 28th Street Balto, MD Mary E. Thomas-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Zion Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-9-2010 Lansdown, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H ento M 1101 E. North Avenue Balto, MD21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

ASPURATUS N

PNELMS NI Approximate Interval Between Onset and Death IRATION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 4SPHAGLA **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Accide crebrovasculer or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 No ed by the detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à NEURYS 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No **Division of Vital** 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one examiner? 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of D ath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No death. after death Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 ho
To the Fune and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) thew Mc No-Snew

State Registrar 31. Date filed (Month, Day, Year)
JUL 12 2010

32. Registrat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 July Race Crosby Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery <u> Montegmery General Hospital</u> If Under 24 Hrs. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number Age (In yrs. last birthday) (Month, Day, Yei 3-23-1921 Days Min. Year 1 XM 2 🗆 F Director 29 220-09-5286 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. Count 10d. Inside City Limits Town or Location Brookville 10c. City, Director Montgamery 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20833 USA Funeral 21212 Denit Estate Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: African-American "natural", Completed 3 √ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene.

item 27 is marked other than '
other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Long Reach Shipvard 10th Welder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) þ Thomas P. Jones Mary S. Booker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 15 College Street, PineForge, PA 19548 Deborah J. Brown/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 7-13-2010 Cypress, CA Forest Lawn Meni. Park Signatu of Funeral Service License 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty ROad, Randallstown, MD 21133 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ lure 0 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires th within 24 hours after death.

To the Funeral Director: After this certificate has been signs completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Record Non traumatic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes မ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 12 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 D0068026 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar PADMAJA BANDI

31. Date filed (Mapth, Day, Year)

Bark

PRINCE

18101

Registrar's Signature

PHILIP

20832

MD

OLNEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of D Physician/ ELLIE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5319 Catalpha Road Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth g. Birthplace (State or Foreign 1 □ M 2 F Days Sept. Day 7 - 1943 Virginia Director 215-40-4295 66 Usual Residence of Decedent or 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Yes 2 No N/A Baltimore Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5319 Catalpha Road 21214 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1★ Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black "natural" 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is one. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) Assembly Line Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pleston Johnson Alice T. Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5319 Catalpha Road Baltimore, Maryland 21214 Shanon Saulsbury/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Zion Cemetery 7-20-2010 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/) Medical resulting in death) Examiner Sequentially list conditions, if any leading to instruction cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a doi sequence of; the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: es, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at a be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital o within 24 hours af To the Funeral D completed filled ii Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pranticiper To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier U 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:40 Margare **Physician** 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death **Examiner** Charles Village Future Care -Baltimore 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 13, 19 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 1 1 F 1919 Director 219-16-2769 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County d other than "natural", or Items 23a or 28a-f ahow event, the Medical Examiner must be natified at 1 XYes 2 □ No Baltimore MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 USA 124 West Franklin Street permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: black 1 ☐ Yes 2 🔯 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) senior aide 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Alice Mitchell William Henry Joyce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 459 Leslie Street; Newark, New Jersey 07172 Cecelia Baulkman - cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee . Wage 22. State Anatomy Board; 655 West Baltimore Street any ir w Baltimore, Maryland 21201 23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Dealf tmmediate Cauce (Final disease or condition monthe **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Am Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Physician/Medical attending IF FFMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown by 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Nnknown 3 Probably 2 🗆 No 1 Tyes Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2 s autopsy performed? 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one Hospital: 1 | Inpatient Certification: To 2 **X**No 2 ER/Outpatient 3□ DOA 4 Mursing Home 5 Residence 6 Other (Specify) 1 TYes 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Accident 5 Pending Injury 2 No 1 Tes Director: A investigation 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 2 Suicide 4 T Homicide within 24 hours a 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010 Than toon, 30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

gistrar's Signature

		For State Registrar		State of Ma	aryland	/ Depa	artment of F tificate of D	ieaith a Death	and IVI		gieno Reg. N		21566
Physicia	an/	1. Decedent's Name			· ·					2. Date of De		^{ay} 2010 ^{Year}	3. Time of Death
Medic Examir	cal	F1a			aufman	1	4b. City, Town, or	Location o	of Death	- 07	$\overline{}$	c. County of Death	7:25 A M
Exami	iei		t Hospice				Tow					Balti	
Funeral Director		5. Social Security Nu 214-82-83	358	x □ M 2 🖟 F 7. Age	e (In yrs. last 99	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs Min.	8. Date of Bir (Month, Da June 2	y, Year)	9. Birti Cou	hplace (State or Foreign intry) MD
and show	o.	Usual Residence of 10a. State	10b. County		10c. City, T	own or Loc	cation						10d. Inside City Limits
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eath w tems 2 er mus	Funeral Director	11. Marital Status	gnts what	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of Hi f Yes, specify Cuba			ify Yes or No-		14. Race - Amer	rican Indian,
If by Mal yiell (A L L L IS-0030) I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Marri 3 XX Widowed 4	ed 2 Married 1 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.	No		Yes, specify Cuba		, Puerto R	ican, etc.)		Black, White Specify: W	hite
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Iryid buld be d Men marke matic	-	Charles 1	M. Lewis me/Relationship (Ty	ne Print)		10b Mailin	ng Address (Street a			ırdette	_	or Town State Zin	Code)
d 2 sho d 2 sho alth an 127 is er trau			Kaufman -		Ī		Wrights						
parmit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		20a. Method of Disp		Removal from State		ce of Dispo netery, cren	sition (Name of natory or other plac			ate		Location - City or	,
Deliminor Dermit, Page 1 Department of mportant: If it any injury or o		4 Dopation	5 Other (Specify)	Loud		ark Cem.						Maryland
permit. Departr Importa any inju		21. Sign turn of Fur		سَيد مرافع									al Home at , MD 21075
Ph sician/		shock, or hear Immediate Cause (I	t failure. List only or Final	olications that caused ne cause on each line	the death. I	Do not ente	er the mode of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	•	a. Due to (or as									UTY.S
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cate be executed physician and sthe burial-transit	edical Examiner	resulting in death) L	ast	Due to (or as	a consequer	ice of):	-						
cate by physic s the b	edic			d							- 1		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?	23c. if yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic pregnand Other (specify)	y				23d. Date of del Month	ivery Day Year
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d lan: Th	Be C	25. Was case referre	ed to medical				26. Pl	ace of Deat	th (Check	1 🗌 Yes	2,	No 1 Yes	2 No
hysician this certifi al director	은	1 Yes 2	24/0			R/Outpatier	nt 3 DOA Othe	4 ⊔ Nu				6K Other (Spec	IN HOSPICE
iding P iding P ith: After t	cate	1 Natural 2 Accident	5 Pending Investigation	28a. Date of inju (Month, Day		injury	work	γat ? Yes 2□	- 1	8d. Describe	now inji	ary occurred	
I or Atter after dea Director	Certificate:	3 Suicide 4 Homicide	6 Could not be determined	-		e, farm, stre	eet, factory, office		2	8f. Location (City or To	Street a	nd Number or Rui te)	ral Route Number,
Hospita 24 hours Funeral	edical	(Check 2	Medical Exami	sician: To the best of ner: On the basis of e se Practioner: To the	xamination a	nd/or invest	tigation, in my opinio	on, death oc	curred at t	he time, date a	and plac	ce, and due to the	cause(s) and manner state
To the vithin To the comp	Σ	29b. Signature and		00/1		_	29c. License	number			29d. D	ate signed (Month	n, Day, Year)
		P		20	10			439			_	4146.	
1		30. Name and addre	ess of person who o	ompleted cause of d	eath (Item 23	3a) (Type, F	Print) CHARLE	5 511	841	TE 410	25	BALTIMA	REMO 21204
Sta		31. Date filed (Monti	T, Day, Year)	32. Fegistra	ar's Signatur		See del	<u>·</u>					
Registr	ar		JUL IZZU	11 Lener	m p	1.							

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	Physicia Medic	al .	1. Decedent's Name (First Middle, Last)		050	919		<i>,</i>		2. Date of D	/ D	7,2018	3. Time	of Death
-	Examin	O'I		okins 13	ay L	lieu	1	351	Location of	re		c. County of Death	mor	e
	Funeral Director		Z 10-00-3 104	M 2 X F 7. Ag	e (in yrs. ia 60	est birthda Yrs	Months	er 1 Year Days	If Under 2 Hours	4 Hrs. 8. Date of Bi Min. (Month, D April	rth a <u>y.</u> Year)	9. Birth Co <i>u</i> i	place (State htry) ndia	e or Foreign
	show at	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or	Location						10d. Inside	City Limits
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		Maryland Baltimor	e		R	<u>eister</u>		1					es 2 XNo
	th the 3aor t be n		10e. Street and Number				10f. Z	ip Code	1126		10g. C	Citizen of What Cou		
	ath wi	Funeral	4 Woodward Cour	2. Was Decedent E	Ever in U.S	S. 1	3. Was Dece		1136 ispanic Origi	in? (Specify Yes or No Puerto Rican, etc.)	-	14. Race - Ameri		
9	ter de , or ite amine	by F	1 Never Married 2 😾 Married	Armed Forces? 1 Yes 2 X If Yes, Give	No				n, Mexican, Specify:	Puerto Rican, etc.)		Black, White,		
8	ours and rtural" al Exa	sted	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates.	-	160 Do	ecedent's Us				166	Kind of Business Ir	dian	
21215-0036	an "na Medio	Completed by	(Specify only highest grad		54)	(G	ive kind of w e. DO NOT u	ork done d	during most	of working	160.	Kind of Busiless if	idusti y	
212	ed within Hygiene. other thai ent, the N	မ ငိ		2			Home	make:				Own Home	:	
Maryland	e filed ntal Hy ed oth event	To B	17. Father's Name (First, Middle, Last) Kesava Rao Chow	lary	_ 7:	7 - 1 1	rupall		_	r's Name <i>(First, Middle</i> varatnam		^{n Surname)} Veeramac	nenen:	i
Ž	should be file h and Mental H 7 is marked o traumatic eve		Kesave Rao 19a. Informant's Name/Relationship (Typ)	Choudhar e, Print)	y					or Rural Route Numb				
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Baltimore,	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ F	temoval from State	C	emetery, (sposition (Na crematory or	other plac		Date	1	Location - City or 1		
<u>Hi</u>	permit. Page Department Important: I any injury o		1 ☐ Burial 2 🛱 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Fune Service Lidensee		Hi1	l1top	Servi	ce C	orp.	7–17–20 <u>10</u>			Maryla	
Ba	permit. Departr Imports any inji		13/12/11	Ban	-	1			Road	Towson,	wson Mar	Funeral yland 2	1204	, шс.
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-	h sician/	8	Immediate Cause (Final disease or condition	Fire	In	iw	25					4	Onset ar	id Death
-	Medical Examiner		resulting in death)	Due to (or as	a conseq	ence of):	Ore	cah	Fail	ure		we	_	
		iner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):)	-	ure modelt	ul) CLV	INER	
ď.	executed an and rial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as	S Consequ	uence of:				1 george		D BY MEDICAL		
) h	be exe sician a burial	I— I	resulting in death) Last	•					(TEICATION	APPROVI	O BY WEDICH EXP		
376	ificate ig phy as the	Medi	IF FEMALE:							CERTIF				-
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physicia for the Funeral Director; After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the business of the business.	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🔲 Feta	al death	3 Ectopi 5 Other		су			23d. Date of deli Month	very Day	Year
P.O.	v requires that the de sbeen signed by the should be detached	by Ph	Part II. Other significant conditions cor	tributing to death I	out not res	sulting in t	he underlyin	g cause gi	ven in Part I			use contribute to		
Division of Vital Records,	equire een si hould b	Completed by					<u></u>			24a. Wa		24b. Were aut		
eco	e law r s has b ge 2 sl	ldu		-				-		aut	opsy formed?	prior to c	ompletion of	of cause of
<u>e</u>	sician: The law I certificate has b lirector, page 2 s	Se Co	25. Was case referred to medical					26. P	lace of Deat	h (Check only one)	s 2 A	No 1 les	2 🗆 140	
Z.	Physici this cer al direc	To Be	1 the Yes				atient 3 🗆		4	rsing Home 5 Re			fy)	
n of	ding P h. After t funera	ate:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju	y, Year)	28b. Tim inju	iry	28c. Injui wor		No Stale		ury occurred Set SELF a	in fiv	-111
isio	Attendar deat	rtific	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ini	6,2610 ury - At ho	ome, farm	KNOW , street, facto			28f. Location	(Street a	and Number or Rui te) 4 Wood&	al Route Nu	umber,
Οį	ital or irs afte al Din led in	a C			fam	1114V	reside			Reis	fers	town, M	<u> </u>	
	Hospi 24 hou Funer eted fil	Medical Certificate:		er: On the basis of	examinatio	n and/or in	nvestigation,	in my opini	on, death oc	curred at the time, dat	e and pla	ice, and due to the o	ause(s) and	manner stated.
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Ž	only one) 3 Certifying Nurse 29b. Signature and title of certife	1		iy knowled	2	ac Licens	e number		29d. [Date signed (Month	. Dav. Year)	
			> SC/Sch	W O b	56			D5	385	0		July 7,	201	0
	20		30. Name and address of person who co	mpleted cause of	death (Iten	n 23a) (Ty	pe, Print)	Jac	145/	Hopkins	B	ay view	_	
	Sta Registr		31. Julied 12 2010 (ear) Len	32. Regita			9			,				

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H <i>rtificate of D</i>			0010	2150
			Decedent's Name (First, Middle, La.	st)		Timodio or B	- Catiri	2. Date of Deat		3. Time of Death
	Physicia Medic	al	Phoebe Knowles					July	1 ^{Day} 201	
	Examin	er	4a. Facility Name (if not institution, given Gilchrist Hospic			4b. City, Town, or Towson	Location of Death		4c. County of De Baltim	
	Funeral		Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	yearlo o o	irthplace (State or Foreign
	Director		145-26-3067 Usual Residence of Decedent	☐ M 2 🖾 F	80 Yrs.	Worth Days	Trodio 14mm	Sept 5,	71929 Ne	w"Jersey
	land show dat	tor	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary 28a-1	Jirec	MD Baltin	nore	Towson					1 ☐ Yes 2 🔀 No
	should be filed within 72 hours after death with the Maryland and Montal Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 615 Chestnut Av	renue		10f. Zip Code 21204		1	10g. Citizen of What 0	Country?
	items items	Fune	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spendar)	ecify Yes or No-		nerican Indian,
36	al", or	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 1 1 If Yes, Give Year or Dates.	No	1 Yes 2 No		,	Black, Wh Specify: wh	nite
2-0	hours hatur dical E	olete	15. Decedent's E (Specify only highest gi	ducation		dent's Usual Occupa		ina	16b. Kind of Busines	s Industry
121	thin 72 ene. than ' he Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5-	life. L	ial worke	_	ing .	Dept of	Aging
д 5	iled wi	Be (17. Father's Name (First, Middle, Last)	<u>J</u>	300	Tar worke	18. Mother's Nam	e (First, Middle, N		
ylar	ld be f Menta narked atic e	욘	Alston Barrett				Aureli	a Ha11		
, Mar			19a. Informant's Name/Relationship (Robert Knowles		19b. Mail 1 -	ing Address (Street a -F Parkway	nd Number or Run Road; G	al Route Number, reenbelt	City or Town, State, 1, Maryland	d 20770
Baltimore, Maryland 21215-0036	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place	e)	Date	20c. Location - City	or Town, State
Balt	permit Depart Import any inj once.		21. Signature of F	Naxlox 1/cy/1	2		atomy Bo			more Street
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	plications that caused one cause on each line.		ter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	hy sicia n/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Le to (r as a	consequence of):	nre				day's
	Examiner	<u>.</u>	Sequentially list conditions,	b. howel	06s huch	4				days
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequence of):	25.5				Menon
	certificate be executed nding physician and use as the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):	73.7				0,700000
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BOX 68/	certific nding use as	Σ∣	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves. 2 M No.	4 Pregnant at	Fetal death 3	Ectopic pregnancy	у		23d. Date of o	delivery Day Year
O. H	t the d by the stached	Phys	1 Yes 2 No 9 Unknown	9 Unknown	A A (Air in Air		on in Book I			
ds, r	quires tha en signed ruld be de		Part II. Other significant conditions of	_	_	rest (en in Paitti.			to the cause of death? Probably 4 Unknown
Records,	he law re tte has be vage 2 sho	Completed by	<u> </u>					24a. Was ar autops perforr 1 🗆 Yes	sy prior t med? death	autopsy findings available o completion of cause of ? //es 2 🏻 No
Vital	cian; ertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:		26. Pla	ace of Death (Chec	k only one)	15	
OT V	r this caral dir	일	1 ☐ Yes 2 2 No 27. Manner of Death	1 Inpatie	nt 2 ER/Outpatie	nt 3 🗀 DOA	4 U Nursing Ho		ence 6 Other (Sp.	ecity) to 30 Le
00	ending sath. or: Afte he fund	ficat	1 Natural 5 Pending 2 Accident Investigatio		Year) injury	M 1 🗆	? Yes 2□No			
DIVISION	tal or Att	I Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or F , State)	Rural Route Number,
	to the Hospital or Atending Physicians: The law requires that the death within 24 burs after death. To the Funeral Director. After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a	Medical	(Check 2 Medical Exam	sician: To the best of n iner: On the basis of ex- se Practioner: To the b	amination and/or inves	stigation, in my opinion	n, death occurred a	t the time, date an	d place, and due to th	e cause(s) and manner stated.
	Voith To t		29b. Signature and title of certifier	hus		29c License	number 30	3	9d. Date signed (Mon	
			30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	Print) 701 N-	Clurc	- S+	Touson	2010
	Stat Registra		31. Date filed (Month, Day, Year)	32. egistrar	's Signature	arlos				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 21569 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year JULY Month HATTIE LOTT 10 10:00a [™] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 1 M 2 YF 218-64-5672 08/16/1915 **Director** 94 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits BALTIMORE BALTIMORE 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11 SLADE AVENUE, #811 21208 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced WHITE Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) econday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ LOUIS GANN LILLIE SINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANNE L. BELGRAD/DAUGHTER ROGERS AVENUE, BALTIMORE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY! 7/11/2010 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician. ASM disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence off. attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year ned by the at edetached for Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been sign page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No Yes 2 No completed filled in by the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **X**No 1 Nipatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 3 Suicide Investigation 1 Tes 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 only one) D0044018 07-10-2010 30. Name and address of person who completed cause of death (Item 23a) Type, Print) GBMC BALTIMURE, MDZ1204 32. Registrar's signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10^{Day} Month ()7 Physician/ 2010 01:05 Loiero Vincent Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Towson Gilchrist Care Center Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 🕱 M 2 🗆 F Months Hours M27117193 Director 213-28-6916 78 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mexical Exercises. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21206 5827 Plumer Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Was Decedent Ever in 0.3
Armed Forces?
1 | ▼ Yes 2 □ No
If Yes, Give 1952-54
Year or Dates. Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Maintenance Foreman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Giralico Maria Peter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5827 Plumer Avenue, Baltimore, MD 21206 Joan C. Loiero, Wife Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Svc. Corporation 07/14/2010 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee 5305 Harford Road, Baltimore, MD 21214 Meyandria & Blan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DACTONTO disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 Tes this certificate has been ral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 10501C0 မ 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpa 6 2 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. R State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 28, 2010 1900 рм Ruth Evelyn Lassiter 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PG Washington Adventist Hospital Takoma If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/11/1939 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 □ XF 71 578-54-7090 N.C. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1
▼Yes 2 □ No Washington D.C. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20002 USA 51 Franklin Street, N.E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 🕍 No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Chef Private year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary E. Slade Clayton Daughtry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20002 Maria A. Lassiter/Daughter 51 Franklin Street, NE; WDC 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 7/9/2010 Washington, DC 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licenses 4594 Beech Road; Temple Hills, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, achieve the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, achieve the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, achieve the disease, or complications that caused the death. Immediate Cause (Final ARDIOPULMONARY disease or condition resulting in death) Due to (or as a consequence of): MYOCARDIAL Due to (or as a consequence of): DIABETES MELLITUS Due to (or as a consequence of): HYPERIENSION 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

sician and burial-transit

attending physician for use as the buria

signed by the a d be detached for

cate has been si page 2 should b

his certificate h I director, page

funeral c

filled in by the

completely

To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate ha

law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certification: To

Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Modical Expringer must be rediffed as once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 □ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 ☐ Inpatient 2 区 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

performed,

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

29a, Certifier (Check only one)

1 X Natural

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

HAMOVERPARKWAT GREENBELT MARTLAND 2070 31. Date filed (Month, Day, Year) 12201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** 1609 M Ellen Linthicum lune /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) unk **Funeral** Days 1 □ M 2**X** F Nov 1, 1949 Director 60 214-58-5758 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location death with the Marylan ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No MD Towson Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21204 USA 509 East Joppa Road Funeral Health and Mental Hygiene. em 27 is marked other than "natural", or items ? ther traumatic event, the Medical Examiner mu 14. Race - American Indian, Black, White, etc. 12. Was Decedent Fyer & U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tra Good Samaritan Hospital 5601 Loch Raven Blvd; Baltimore, Maryland 21239 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5點Other (Specify)In state 21. Signature of 5 year Legrice Aicensee Naylo 22. State Anatomy Board; 655 West Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASON 1 Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-trans Due to (or as a consequence of): attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 □ Yes 2 □ No Pregnant at time of death 5 Other (specify) his certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 1 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann Death funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation n 24 hours after death. le Funeral Director: Af bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 2 To the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

29b. Signature and title of certifie

29c. License number MD

29d. Date signed (Month, Day, Year)

5601 Loch Raven Boulevard, Baltimore Maryland 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yay

and manner stated

31. Date filed (Month, Day,

32. Redistrar's Signature

completely

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Richard Joseph Morgan 3Day July 20Î 6:19 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Dunda1k 7823 West Collingham Dr. Apt. A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 220-76-0169 1**X** M 2 □ F Months Hours (Month, Day, Year) Ct. 26, 1958 Mary land 51 Oct. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Dunda1k MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 7823 West Collingham Drive Apt. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give 1 ☐ Yes 2XXNo Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Truck Driver Trucking Industry Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joyce Leight Richard Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3483 Dunhaven Road Dundalk, Maryland Gary T. Morgan 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Hilltop Service Corp. 7/8/2010 Towson, Maryland 4 ☐ Donation _5 ☐ Other (Specify) 21. Signatu e o netal Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 <u>Wise Ave.</u> Dundalk, Maryland 21222 23a. Part 1. Ente the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Acquired resulting in death) Sequentially list conditions, if any leading to immediate

Physician/ Medical Examiner

permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I

Physician/

Medical

Director

Funeral

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Completed

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Funeral

Director

should be filed within 72 hours arrest and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show arrest cevent, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

attending physician and for use as the burial-transit Physician/Medical signed by the a d be detached f 2 been sig Completed page 2 s has B P this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate:

edical Examin	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequence	NT 2	:					
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlying cause given in Part I.	2001 210 102000	o use contribute to the cause of death? 2 No 3 Probably 4 Tonknown				
Completed				24a. Was an autopsy performed? 1 □ Yes 2 ☑					
Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)					
일	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/0	ospital: 1						
Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	. Time of injury at work? M 28c. Injury at work? 1 Yes 2 I	28d. Describe how inj	ury occurred				
al Certi	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medical	(Check 2 L Medical Exam	iner: On the basis of examination and	e, death occured at the time, date and p d/or investigation, in my opinion, death occurred at the time, date a	curred at the time, date and pla	ce, and due to the cause(s) and manner stated				

D0066579

Hospital, 600 North Work Street, Carnogie 346, Baltimore, Mary land 21287

29d. Date signed (Month, Day, Year)

,6,2010

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Emily Sydnor M.D., Johns Hopkins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-05001 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0140 hrs Warren J. Mitchell **Medical Examiner** July 4, 2010 4c County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Johns Hopkins Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year 5 Social Security Number **Funeral** Months Davs Hours 12-25-1986 N.Y. Director Country) 055 - 72 - 47561XXVI 23 2 F Usual Residence of Decedent 10d. Inside City Limits City, Town or Location any 10a. State 10b. County Baltimore MD na Yes 2 No or 28a-f show items 23a or 28a-f shoust be notified at once. hours after death with the Maryland Director 10g. Citizen of What Country?
USA 10e Street and Number 4106 Mapel Shade Drive Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after de
Department of Health and Mental Hygiene.
Importants If item 27 is marked other than "natural", or i
ningy or other traumatic event, the Medical Examiner mu Specify: Black Yes 2 X No specify. If Yes, Give Year 3 Widowed 4 Divorced ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) na leted during most of working life. DO NOT use retired)
Unemployed Elementary/Secondary (0-12) College (1-4 or 5+) Compl 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Debra Ann Mitchell Denzil R. Labbar Be 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9595 Shirewood Ct Rosedale, MD 21237 Juwana Mitchell-Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 7-12-2010 Baltimore, MD Greenmount 4 Donation 5 Other Specify March East F/H 22. Name and Address of Facility 21. Signature Funeral Service Licenses 1101 E. North Avenue Balto, MD 21202 23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Mudical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit The law requires that the death certificate be executed Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Box 68760, 23d. Date of deliver IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been s I director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) or Attending Physician: Division of Vital Be Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) Jul 3, 2010 28d. Describe how injury occurred After t 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject shot 2238 hrs Natural 1 Yes 2 ✔ No after death.

Director: A in by the fi 5 Pending Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide or Town, State) 1600 North Port Street, Baltimore, Md. within 24 hours a To the Funeral I determined (Specify) Local Street Hospital 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifie July 4, 2010 O.C.M.E Veek Elle 2 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registre s Signature filed (Morth, Days Year) State Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ::)-04741 State of Maryland / Department of Health and Mental Hygiene k halifah Muhammad 2010 21575 Certificate of Death 1. For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 23, 2010 2305 hrs led≔l Examiner Muhammad Khalifah c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring SB Layhill Road before Middlevale Drive 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Wash. If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number oreign Country) **Funeral** Hours Months Davs DC 12/11/1990 Director 2 F 19 1 M 212-51-1697 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturor". 1 Yes 2 X No Silver Spring Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20906 12809 <u>Saddlebrook</u>Dr. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 Married 1 Yes 2 X No Specify: Black 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year 3 Widowed é 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) pleted College (1-4 or 5+) Elementary/Secondary (0-12) Morehouse College Student Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Muhammad Nisa Be Muhammad Anthony 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2015 Alabama Ave.SE Washington, DC 20020 Anthony Muhammad / Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Washington, DC 6/28/10 Rock Creek Ceme. 4 Donation 5 Other Specify: Universal Mortuary Inc 22. Name and Address of Facility 21. n e of Funeral Service Licenses DC 20011 411 Kennedy St NW, Washington, Approximate Interval 23a. Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death **Viedical** a. Injuries of the Head and Upper Extremity Immediate Cause (Final disease *k*aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Exami Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED tending physician are use as the burial -23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death 1 Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ğ Completed 24b. Were autopsy findings available 24a. Was an has been s e 2 should l prior to completion of cause of autoosy death? performed? 1 Yes 2 No Yes 2 ✔ No 26.Place of Death (Check only one) l or Attending Physician: after death. 25. Was case referred to medical Division of Vital Be Other Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA After this 1 🗸 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Jun 23, 2010 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Passenger auto fixed object collision Certification: 2235 hrs 1 Yes 2 ✔ No Natural Pending Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) SB Layhill Road before Middlevale Drive, Silver Spring, 6 Could not be 3 Suicide To the Hospital c within 24 hours af To the Funeral D determined (Specify) Major Road / Highway Homicide 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signaly June 24, 2010 O.C.M.E Vel 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Victor Weedn MD JD 31. Date filed (Month, Day, Year) 32. Registear's Signature State

Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2010 21576

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	F		A	e (First, Middle,L	ast)							Date of Dea Month	th Day	Year		Time of Death 2320 hrs
Physicia Examiı	11.	1. De	Idris	Raf		Muham	mad					June 23, 2	2010			2320 1113
CAGIIII		4a F	Acility Name (if	f not institution,	give street a	nd number)	illiaa_	4t		or Location o	f Death			County of		
		40. 1	SB Layhill R	Road before	Middleva	le Road			Silver Sp	ring				ontgom		eee /State or
5	-		ocial Security N		. Sex		e (în yrs. last l	oirthday)	If Under 1	$\overline{}$	_				Foreign	ace (State or Wash.
Funeral Director					XM 2	¬e I	20	Yrs.	Months [ays Hours	Min.	7/8/	1989	9	Count	y) DC
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any		_	State	10b. County			10c. City, To	wn or Locatio	on						- 1"	Yes 2 XNo
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th the 23a o notifi	믍	-	12809 Marital Status	Sado	12. W	as Decedent	Ever in U.S.	13. Was	Decedent o	Hispanic Ori	gin? (Spe	cify Yes or N	0-	14. Race White		n Indian, Black,
th wi	Funeral	1	XNever Marr	ied 2 Ma	rried A	med Forces		If Y	es, specify Cu	ıban, Mexican	, Puerto R	ican, etc.)	1			_ ,_
or dea	교	1	Widowed		rced If Yes,	Yes 2 Sive Year				No specify				Specify:		ack
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36 in 72 han	음		•			2		Stu	dent				We	stw	<u>, 00a</u>	College
with grene	Completed	17	Father's Name	e (First, Middle,	Last)					18.Mothe	r's Name (First, Middle)	
al Hy et ed of	Be		Anth	ony	Muhai	nmad				Ni	sa	Muha	amma	d Tou	n State	Zip Code)
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health is marked other than "naturaly", or items 23a or 28a-f show refress marked other than "naturaly", or items 20a or 28a-f show refress the Medical Examiner must be notified at once.		19	a. Informant's I	Name/Relations	nip (Type, P	rint)		19b. Mailin	g Address (Street and Nu	mber or Ru	ural Route N	umber, o	nort.	on D	C 20020
MD day show the and m 27 is	'	A	nthony	uMuhan	mad	/ Fat	her	2015	Alar	oama A	ve.	Date Date	20c.	Location	- City or T	C 20020 own, State
re, MC s 1 and 2 s' of Health au If item 27		20	a Method of D	isposition			20b. Pi	ace of Dispo: ematory or of	sition (Name ther place)	or cemelery,						
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Baltimore, permit. Pages I at Department of He Important: If ite		2	Donation Signature of	5 Other Spruice	Licensee	111	A	22.	Name and Ad	Idress of Facil						y Inc.
Baltimore, permit. Pages 1 a Department of He Important: If its		- 1	110	0 ()	n 1	VIGI	len	41	1 Ker	nedy	St.N	W. W.	ashi	ngt	on, E	C 20011 Approximate Interval
Physicia	_	2	3a. Part I. Enter	r the disease, or	complication	ns that caus	the death.	Do not enter	the mode of	dying, such as	cardiac or	respiratory	arrest, sn	IOCK, OF TH	edi (Between Onset and Death
ledica		١.		only one cause se (Final disease	Imirro	ies of the	Head									Bodu
amine	er	ď	r condition resu	ulting in death)			nsequence of):								
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			fany, leading to	o immediate nderlying Cause		o (or as a co	nsequence of):								
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execute in and	l-tr	ician/Medical	UNPEND	ED .	☐ AN	IENDED										
e be o	burial -	힐	F FEMALE:		23	3c. If yes, out	come of preg	nancy					2	3d. Date Month	of delivery	oay Year
Box 68760, a death certificate be the attending physic	hed for use as the	를 2	3b. Was deced past 12 mo	lent pregnant in	the 1	Live birth			Fetal death	3 Ecto	pic pregna	ancy		MOUTH		, ay
X 6 h cert	nse	흥			nknown a		it at time of de	ath 5	Other (Speci	fy)			.			_
Bo deat	od fo			significant cond				esulting in th	e underlying	cause given in	Part I.					the cause of death?
P.O.	773	함	Part II. Other s	significant cond	itions co	iti ibuting to d	icati) bat not i					1	Yes 2	✓ No	3 Prob	oably 4 Unknown
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 /2010 Essmat Hossein Morad 6:10p M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days Min Months Hours 7 / 11 7 7 92 4 219-27-6347 85 Iran Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4521 East West Hwy. 20814 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2x No If Yes, Give Year or Dates 1 Yes 2 No Specify 3 ₩ Widowed 4 □ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hossein Hossein Morad Ozra Ghandhari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shahram Sharafi 4801 Fairmont Ave. #502, Bethesda, MD 20814 20a. Method of Disposition 20h Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Parklawn Cemetery 7/3/2010 | Rockville, MD 21. Signature of Funeral Service Lices 22. Name and Address of Facility Universal Mortuary Inc. Kennedy St.NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final C. difficile colitis disease or condition resulting in death) Due to (or as a consequence of Acute renal failure Sequentially list conditions, Due to for as a consequence of Congestive Heart failure Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Day Year 2 🔀 No 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner Examiner

and the burial-tran

attending physician

the

signed by

peen s

has

this certificate

To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certified ours after death.

eral Director: After this certific filled in by the funeral director, Physician/Medical

þ

Certificate: To Be Completed

Medical

29a. Certifier (Check

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

Director

28a-f show

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items 23a

"natural", or

than

and Mental Hygie is marked other

permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any jury or other traumatic eve any injury or other traumatic evenes.

event, the Medical

within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

Completed by

Be

2

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events cartifling in death) I ast resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

5.	Was case re examiner? 1 Yes	eferred to medical
,	Manney of F	South

26. Place of Death (Check only one) Other: 1 Phopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No

27.	Manner of Death	
	Natural	5 Pending
	2 Accident	Investigation
	3 Suicide	6 Could not be
	4 Homicide	determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

Yes

autopsy performed

2 No

	only one	3 L Certifying	Nurse Pra	(C
29b.	Signature	and title of certifier		
		Mm	-7	7

tioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

662 BC)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

State Registrar Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Amend Items State of Maryland / Department of Health and Mantal dygiene Certificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Hampton Daniel Moran 2010 7:39 PM June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 518 E. Garrett Street Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months 11X M 2 □ F Director June 26, 1946 Maryland 63 212-42**-**8096 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, Tra Medical Examinat must be rigitlied at 1√2 Yes 2 □ No Director Baltimore MD death with the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21225 518 Garrett Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Never Married 2 Married white 1 ∐Yes 2X No ģ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 11nk Elementary/Secondary (0-12) College (1-4or 5+) 12 6 bookeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Mildred Johnson Francis Daniel Moran ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5007 Plymouth Road; Baltimore, Maryland 21214 Bernard Wamhoff - friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Cremation 5 ☐ State 21. Signature of Funeral Servi 22. Name and Address of Facility State Anatomy Board; 655 West Baltimore Street Baltimore, Maryland 21201 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heliatiali 6K 2006 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 200 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine memia requires that the death certificate be executed 2000 and burial-trar Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 No this certificate Division of Vital 25. Was case referred to Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, p. medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry 5075 2010 Choi, MD 1201 N. MI 32. Registrar's Sigrature 31. Date filed (Month, Day, Year) State 122010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Y TUSERH 7:55 PM PANICO MUZZOCCO 7010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death COUNTY SCHAPLIPL HOTPITA HOWARD Homan Corumsia If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Hours (Month, Day, 89 215-12-8230 Director MD Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MD Ellicott City 1 Yes 2 X No Howard 10e. Street and Number 10g. Citizen of What Country? Funeral 4475 Montgomery Rd. 21043 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married ģ Yes 2 ☐ No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Specify: White "natural". 3 X Widowed 4 □ Divorced Completed Year or Dates. WW II the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Schools Elementary/Seconday (0-12) College (1-4 or 5+) of Maint. Superviser Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dionigi Giuseppina Guariglia Marrocco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Dr. David D. Morrocco-Son 6430 Galway Drive Clarksville, Md. 21029 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 7-13-10 Baltimore, Maryland Stanislaus 4 Donation 5 Other (Specify) 21. Signat pf Fuper price Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. S Conkling St 21224 263 Baltimore. Md. Page . For the diseate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or con Irion Physician AWTE NOSPINATINY 2 WEEKS Medical resulting in death) Examiner Proumora 2 WHERES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, CONGESTIVE INPAINT 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? MISULTERSIN 24a. Was an has page STANKE performed' 2 3 No certificate 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛂 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work' To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Registrar's Signar re

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID O WYANTON

D36974

10710 CHARTER DRIVE, SUITE 310,

JUL 09

2010

COLUMBIA MO 21044

it it item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at. death with the Maryland melanghlin, Maryland 3 attending physician and

State of Maryland / Department of Health and Mental Hygiene For State Registrar 21580 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:33PM ALMA Mc LAUGHUN 2010 Jely Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Bastimore Hinoro 8. Date of Birth Aug 7, 1927 **Funeral** If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🖾 F New York **Director** 105-22-3167 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3503 Plateau Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐**X**No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir once. Completed by 1 Never Married 2 Married Specify: black 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) healthcare nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Samuel McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Peoples - guardian 4321 Mary Ridge Dr; Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ♣ Other (Specify) in state Signature of Pureral Service Licensee Naylor ^{22.} State Anatomy Board; 655 West Baltimore Street 1/0 Raltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cenns disease or condition **Medical** resulting in death) Due to (or as a consequence of) Examiner washis Atheroschrosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes 2 No completed filled in by the funeral director, B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this 28c, Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defining Physician: to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practionum: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NJahuz D7 5113 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltimor 5+ Marl [ABUNDAY= ROLAND 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 10:00 PM David Moore June 28 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 302 E. Joppa Road #602 Towson Baltimore 8. Date of Birth (Month, Day, Sept 9, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1⊠ M 2□ F Months Days Hours Virginia 78 215-24-2046 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No Baltimore Towson MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 302 E. Joppa Road #602 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1★□Yes 2□No 195
If Yes, Give
Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. within 72 hours after 1 Never Married 2 Married 1953-Baltimore, Maryland 21215-0036 white 1 ☐ Yes 21 No Specify ģ 3 Widowed 4 Divorced 1955 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 technician research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Eugene Walter Moore Lois Luzell Hudson ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an important: if Item 27 is any Injury or other trau 302 E. Joppa Road #602; Towson, Maryland 21286 Sandra Moore - spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice Licen ^{22.} State Anatomy Board; 655 West Baltimore Street Maylor Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o the detached 9 Unknown ģ ۵. s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ a No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 sl 24a, Was an autopsy perform 1 Tyes 2 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1∕ Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) and Wy 65 31. Date filed (Month, Day, Year) 2120 32. Regiorar's Signature State Registrar

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leuicai	CXaIII	mer	Ralph William Mills 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	July 4, 2010	4c. County of Death	2259 1115				
			Western Correctional Institution	Cumberland		Allegany					
	uneral rector		5. Social Security Number 11	Months Days Hours M	Hrs. 8. Date of Birth Min. May 5,	(MM/DD/YYYY) 9. Birti 1964 Foreign Cou					
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the Maryla	23a or 28a-f show notified at once.	Director	10e. Street and Number 13800 McMullen Highway	10f. Zip Code 21502	100	g. Citizen of What Coun USA	try?				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland	or items 23	Funeral	1 Never Married 2 Married Armed Forces?	Vas Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue		14. Race - Americ White, etc.					
urs afte	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Whit of Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Unit 16b. Kind of Business/Ind										
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212 ould be	d Ments s mark ic ever	To B		ing Address (Street and Number of		er, City or Town, State,	Zip Code)				
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Baltimore, permit. Pages 1 ar	Department of Health and Mental Hygiene. Important: If item 27 is marked other th injury or other traumatic event, the Med	П	1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 X Other Specify: in State Crematory or Final Jo Cremato		Date // 28/2010	20c. Location - City or 1					
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B Pe	Departi Importi injury	Щ	Baltimore, Maryland 21201, PO, Box, 1413, 21203								
/Me	sician edical miner		23a. Fart I. Enter the disease or complications that caused the death. Do not enter fail re. List only one cause on each line. Immediate Cause (Final disease a. Complications of Blunt Force Injuries)	r the mode of dying, such as cardiac	c or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death				
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876(tificate	ng phy as the b	M/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 F	Fetal death 3 Ectopic preg	ınancy	23d. Date of delivery Month Da	ay Year				
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Division pital or Attendia	24 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Jail/Penal	eet, factory, office building, etc.	or Town, Star	eet and Number or Rura te) e of Corrections, Jess					
Divis Fo the Hospital or	within 24 hours after d To the Funeral Direct completely filled in by	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.								
	0	Ž	2918. Signature and title of certifier Activate and	29c. License number O.C.M.E.		29d. Date signed <i>(Mont</i> July 14, 2010	h, Day, Year)				
			20. Nime an laddress of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Pen	n Street, Baltimore, MD 21	201						
	St	ate	31. Date filed (Months Payses) 2010 32 Registrar's Signature	n oneet, Daitimole, MD 21	201						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Deat 3. Time of Death Physician/ onth 2cA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE BALTIMORE @ NORTHWEST HOSPITAL RANDALLSTOWN **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 XF 0370771919 91 MD Director 219-07-5562 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD BALTIMORE BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8152 SCOTTS LEVEL ROAD 21208 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Specify: Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 h t of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATOR LEUKEMIA SOCIETY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SNYDER KATE CAPLAN 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important; If item 27 is any injury or other trau KAREN NEEDLE/DAUGHTER 8371 BLACKBURN AVENUE, #10, LOS ANGELES, CA 90048 Baltimore, 20a. Method of Disposition 20b. Plate OBTE Opti Sk Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BENEFICIAL CIRCLE LDG: 7/12/2010 BALTIMORE, MD SOL LEVINSON & BROS., INC. 21. Signature of uneral Set 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause are each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) Yes 2 No 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ icate has been sig 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မ 2 **N**0 To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. bate Print)

State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OBERT 0:55 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 F Days June 20, Year 1935 75 Pennsylvania Director 161-28-1384 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 4 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3505 Gough Street 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 □ No 1957 Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 Divorced 1959 Year or Dates 16b. Kind of Business Industry unk 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 0 sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Weinstein Martin Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3505 Gough Street; Baltimore, Maryland 21224 Mary Portner 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Fure all Service Licensee Naylor 22. Name and Address of Facility Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line rval Between Onset and Death Immediate Cause (Final RESPIRATOR FAILURE Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) PUEUMUNIA been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performe death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending ✓ Natural 1 ☐ Yes 2 ☐ No Accident Investigation s after death ☐ Accider☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar (Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

4940 EASTERN AVENUE, BALTIMORE, M. N. 21224

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Section Sect	
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 Nonth 1 Ves 2 Nonth Nonth Day 1 Ves 2 Nonth Nonth Day 1 Ves 2 Nonth Nonth Day	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the	•
The complete of the complete	Day Year
The complete of the complete	the cause of death?
24a. Was an autopsy performed? 1 Yes 2 Mo 1 Y	
autopsy performed? 1 Yes 2 Mo 1	utopsy findings available
To the part of	i_
To the part of	2 🗆 110
1 Matural 2 Accident 3 Suicide 4 Homicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Roulding, etc. (Specify) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,	cify)
2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,	
4 Homicide Homicid	ural Route Number,
29a. Certifier (Check only one) 29b. Signature and title of certifier (29b. Signature and title of certifier (29b	
29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day,	
	2010
30. Name and address of person who completed cause of beath (Item 23a) (Type, Print) 1801 WENTWORTH ROAD SAIMA KHAWAJA, M.D. BALTIMORE MD 21234	10 4

State Registrar

31. Date filed (Month, Day, Year) — 32. Reg trans Signature

10 127010 Live S. factorial Services

			For State	State of Maryland						21587
			Registrar 1. Decedent's Name (First, Middle, Last)		Cen	ificate of Dea	atn		g. No 2010	
	Physicia Medic			MARGARE	TI	RAE		2. Date of Death Month	Day Year	3. Time of Death 0220 M
	Examin		4a. Facility Name (if not institution, give stre			4b. City, Town, or Loc	ation of Death		4c. County of Dea	th
			Carroll Hospital				inster		Carr	o11
	Funeral Director		5. Social Security Number 6. Sex 1 □ 1	7. Age (<i>ln yrs. last</i> 91	t birthday) L Yrs.		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day Y Jan 15,	^(ear) 1919 ^{9. Bir}	thplace (State or Foreign untry) MD
	d ow t	L	Usual Residence of Decedent 10a. State 10b. County	40. 01.	T					
	ırylan I-f sh ied a	cto	,		Town or Loca					10d. Inside City Limits 1 √√2 Yes 2 □ No
	or 28a notif	Director	MD Carrol	<u> </u>		Westminst	er		g. Citizen of What Co	A
	vith th	ıral	201 St. Mark Way,	Ant. 203		21158		10	USA	ountry?
	ems ermu	Funeral		. Was Decedent Ever in U.S.	13. W	as Decedent of Hispar	nic Origin? (Spe	ecify Yes or No-	14. Race - Ame	erican Indian.
ထွ	ter de , or it		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Yes, specify Cuban, M		Rican, etc.)	Black, Whit	e, etc.
93 03	urs af tural" al Exa	ted	3 X Widowed 4 □ Divorced	Year or Dates.	¹	☐ Yes 2 🔀 No Sp	pecify:		Specify: W	hite
5	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Completed by	15. Decedent's Educa (Specify only highest grade)		(Give ki	ent's Usual Occupation and of work done during		ing	6b. Kind of Business	Industry
72	/ithin iene. r thai	Con	Elementary/Seconday (0-12)	College (1-4 or 5+)		NOT use retired) Lephone Op	erator		Teleph	one
ğ	iled villed volume	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
ylar	ld be f Menta larked atic e	욘	Shane McShan				Mar	rie Demps	еу	
, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2a or 28a-f show other traumatic event, the Medical Examiner must be notified at.		19a. Informant's Name/Relationship (Type, Mrs. Barbara A. Co.	Print) 11ins (Daughte	19b. Mailing er) 9	Address (Street and N 4 Medford	Number or Rura Lane, I	al Route Number, C Berkeley	ity or Town, State, Zi Springs,	wV 25411
Baltimore,	le 1 and t of Heal if item 3		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rei	moval from State cerr	netery, crema	ition (Name of atory or other place)			Oc. Location - City or	·
Ē	it. Page rtment o rtant: If njury or		4 Donation 5 Other (Specify)	Wood		Cemetery		1	Baltimore	*
Ra	permit. Page 1 a Department of H Important: If ite any Injury or otf		21. Signature of Funeral Service Licensee		99 F	O DOX 193	Sykesvi	tite, MD	21/84	& CHAPEL, PA
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complications of the complete shocks are shown in the complete shocks.	ause on each line					,	Approximate Interval Between
	nysician/ } Medical	1	Immediate Cause (Final disease or condition resulting in death)	9a.	eun	wom a				Onset and Death
فمدروه	Examiner			Due to (or as a conse par	nce of): CSPU	atory of	failm	re		
	ed 1sit	Examine	Sequel firally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequen		J	1			
0	a 4	Exa	that initiated events c resulting in death) Last	Due to (or as a consequen	nce of):					
20	certificate be nding physici use as the bu	edical	d.							
200	certific nding I	Ž	IF FEMALE: 23b. Was decedent pregnant	. If yes, outcome of pregnance					23d. Date of de	liven
ROX	death o	Physician/Me	in the past 12 months?	1 Live Birth 2 Fetal d 4 Pregnant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
O.	the d	hys	g 🗌 Unknown	9 Unknown						
S, P.(s tha	ρ	Part II. Other significant conditions other	outing to death but not resulti	Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vinknown				
<u>0</u>	w requ	plete	,					24a. Was an	24b. Were au	topsy findings available
	The law ate has l	Completed						autopsy performe	ed? death?	completion of cause of
ē	ertifican:		25. Was case referred to medical examiner?				of Death (Check			
<u> </u>	Physic this c al dire	2	T Lifes 2 Larino	pital:					ce 6 Other (Spec	ify)
0	ding R h, After funer	ate	1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury at work? M 1 ☐ Yes		28d. Describe how	injury occurred	
DIVISION OF	Atten	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home	e, farm, stree			28f. Location (Stree	et and Number or Ru	ral Route Number,
2	ital or irs afte al Dire		, and the state of	building, etc. (Specify)				City or Town, S	State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completed filled in by the funeral director, pag	Medical	(Check 2 Medical Examiner:	n: To the best of my knowled On the basis of examination ar ractioner: To the best of my kr	nd/or investig	ation, in my opinion, de	eath occurred at	the time, date and I	place, and due to the	cause(s) and manner stated.
	To the Comit	_	001 01 1 1111 6 177							
			and	lotted course of death (in the	2a) /T:= : 5 :	NZ.14		,		
	19		30 Mame and address of person who comp	HOUSE OF GEATH (Item 25	sa) (Type, Pri	r dain	shee	t, wes	twaster	トカ ンループ
	Stat Registra	E	31. Date filed (Month 2 2010)	32. Registrars Signature	evers.					

			_ For	State of	of Marylan	d / Depa	rtment of	Health a	and Me	ental Hy	giene			
			State Registrar			Cert	ificate of	Death_			Reg. No	010	21588	_
	Physicia	n/	1. Decedent's Name (First, Middle	, Last)	20	- r-			2	2. Date of De Month		Year	3. Time of Death	
	Medic	al	LAURA	M.		TER			(D. II)	TULY	05	2010	0947 AM	\dashv
1	Examin	er	4a. Facility Name (if not institution)	KINS BA	HYVIEW	MEDG	4b. City, Town, o	or Location of		=	4c. Co	unty of Death		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 Year	If Under 2	24 Hrs. 8	B. Date of Bir	th	9. Birth	place (State or Foreign	\dashv
	Director		219-16-8762	1 □ M 2 🖾 F	89	Yrs.	Months Days	Hours	Min.	Month Da	" 1920	Mary	Tand	
٦	now at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	ation						10d. Inside City Limits	\dashv
arvar	a-fs ified	ectc	MD		1	altimo							1 ဩ Yes 2 ☐ No	,
the M	or 28 e not	۱	10e. Street and Number				10f. Zip Code					of What Cou	ntry?	٦
with	s 23a lust b	Funeral Director	1300 South El	lwood Ave	enue		21224				USA	A		
death	ritem ner n	Fur	11. Marital Status		edent Ever in U.S proes? 2 🖺 No		as Decedent of I Yes, specify Cub				14.	Race - Americ Black, White,		
)36 after	al", o Exami	d b	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Voc Civ	/e	1	☐ Yes 2 🖾 N	Specify:			Spe	ecify: whi	te	
nd 21215-0036 filed within 72 hours after death with the Marvland	tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by		nt's Education			ent's Usual Occu			8	16b. Kind	of Business In	dustry	
21 3	han " e Med	omp	Elementary/Seconday (0-12)	est grade completed, College (1		life. DC	ind of work done NOT use retired)	ot working		Cot	holio	Charities	
	Hygier other t ent, th	BeC	17. Father's Name (First, Middle, L	4		soc	ial wor		- l- N 0		Maiden Surr			\dashv
<u>a</u>		일	Thomas Maclur	•						h Ricl		iame)		
ary Pould	th and Mer 27 is marke traumatic		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailing	Address (Street	and Number	er or Rural F	Route Numbe	er, City or Tov	vn, State, Zip	Code)	
Z 2 sl	Health a		Janis Doyle -	friend		131	5 Chesa	co Ave	nue #	[‡] 326 ; 1	Roseda	.1e, Ma	ryland 212	37
Baltimore, permit. Page 1 and	T = 0		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from		lace of Dispos emetery, crem	ition (Name of atory or other pla	ice)	Da	te	20c. Locat	ion - City or To	own, State	
t. Page	Department Important: any injury c		4 🖾 Donation 5 🗀 Other (S	Specify)		-								4
Balt	Department of Important: If any injury or once.		21. Signature of Fund Service	Naylor	/	22.		-				Balti	more Stree	t
			23a. Part 1. Enter the disease, or	complications that	caused the death	n. Do not enter	Baltimo the mode of dyi						Approximate	┪
Ph	ysician	8 1	shock, or heart failure. List of Immediate Cause (Final	_	SPIRA	ナハワ	J Tie	TD:	100				Interval Between Inset and De Ih	
1	Medical		disease or condition resulting in death)		(or as a consequ		דוע ו	TRE	(7)				IVA	1
E	xaminer	_	Sequentially list conditions,	b. Cor	16EST	IVE	HEAR	TF	ALL	URE			5 YEARS	4
Q	ji.	Examiner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequ	ience of):								
) be executed	and I-trans	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c	(or as a consequ	ience of):						1		\dashv
o pe e	physician and s the burial-transit	edical		L.										
certificate b	ng phy as the	Med	IF FEMALE:	1										⊣
BOX 58 death certifi	tendir or use	by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregna Birth 2 🗌 Feta	ıl death 3 🔲		псу			23d	Date of deliv	•	
e deal	the at hed fo	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Preg 9 ☐ Unki	nant at time of d nown	leath 5 □	Other (specify) _					Month	Day Year	
that the	ed by detac	y Ph	Part II. Other significant condition	ns contributing to c	death but not resi	ulting in the un	derlying cause g	iven in Part I.	l.	23e. Did to	obacco use	contribute to t	ne cause of death?	٦
S, lires t	n sign Ild be									1 🗆	Yes 2 🗆 N	No 3 □ Pro	bably 4 Unknown	
oro w requ	s beel	Completed								24a. Was			psy findings available impletion of cause of	٦
The la	ate ha	No.								autop perfo 1 Yes	ormed?	death?		
Can:	ertifica ector, I	Be	25. Was case referred to medical examiner?	Hospital:				Place of Deatl	th (Check o					
T VI	this c al dire	<u>유</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 28a. Date	Inpatient 2 -	ER/Outpatient	3 DOA Ott					Other (Specifi)	\dashv
o u	th. After fune	cate	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident Investig	ng (Mon	th, Day, Year)	injury	wor	ryai k?]Yes 2 □		a. Describe r	now injury oc	currea		
DIVISION OT VITAI HECOLDS, tal or Attending Physician; The law requires	ector ector by the	Certificate:	3 Suicide 6 Could	not be 28e. Place	of Injury - At ho	me, farm, stre			28			ımber or Rura	Route Number,	7
DIVISION OF VITAL RECORDS, P.O. BOX To the Hospital or Attending Physician: The law requires that the death	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompieted filled in by the funeral director, page 2 should be detached for use as			Duligi	ing, etc. (Specify,					City or Tov				
Hospi	74 hou Funer ted fill	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the bixaminer: On the bas	est of my knowle sis of examination	edge, death or and/or investi	ccured at the tim gation, in my opin	e, date and p	olace, and ocurred at the	due to the ca e time, date a	use(s) and mand place, and	anner as stated	ed. use(s) and manner state	ed.
the	ithin 2 • the I omple	ž	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner:	To the best of my	/ knowledge, de	eath occurred at t		and place,	and due to th		d manner as s gned (Month,		\dashv
٦	ક≓ઇ			7	人.	40		5-0	an		Till \	J =	2010	
			30. Name and address of person v	who completed cau:		23a) (Type, Pr	int)				سا ۷ ل	-		-
			LAUREN	GRAHA	M M.	D. 4	140 EAS	TERN	.AUF	NUE	BALT	IMORI	E MD 2122	14
	Stat Registra		31. Date filed (Month, Day, Year)		legistrar's Signat	Sa	Not							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per ab g905 7-26-10 vt.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 10:00 PM Claude Rowes 2 July 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis multimedical Center 7700 York Road Towson, Maryland Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1923 Months Days Hours Min. Nov 10, 1922 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 🖾 M 2 🗆 F North Carolina 243-22-8007 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Tyes 2 TXNo Director Baltimore Towson 10g. Citizen of What Country? 10e Street and Number 10f Zin Code ō 21286 1107 Concordia Drive USA s 1 and 2 should be filed within 72 hours after death wi of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a · Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1943-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🖾 No Specify: Specify: white If Yes. Give þ 3 Widowed 4 Divorced 1946 Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) sales manager oil company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Guy Rowe Rosa Lee Yount ပ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Rowe - spouse 1107 Concordia Dr; Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Siner I Service licensee $^{22.\,\,\text{Name and Address of Facility}}_{\mbox{State Anatomy}}$ Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** June 18 2010 disease or condition resulting in death) Freumonia /Medical Due to (or as a consequence of): Examiner onjestive Heart Failure months-years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cardiomyopathy with poorejection fraction law requires that the death certificate be executed Ischemic months-years sician and burial-tran Box 68760, attending physician for use as the buria Diffuse Physician/Medical months-years arterial occlusive disease 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a diffusion by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by moderate to severe aprilic stenosis 3 Probably 4 → Unknown 1 ☐ Yes 2 ☐ No Dysphagia 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Type II Diabetes Mellitus 24a Was an Dementia page certificate Atrial Fibrillation Coronary Artery Disease 1 □Yes 2 ☑No Division of Vital After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 1√0 Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Norse Prachitioner:

[Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospital 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number michello & Kalender, CRN ! R097104

Registrar DHMH 17 Rev 1/2001

State

Michelle E. Kalendak, CRUP Genesis Multimedical Center 7700 York Road Towson, Maryland 21204
31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, 'Year)

10-04866

tam Naga Raja		State of Maryland / Department 1- For State Registrar Certificate			_{19. No.} 2010 21591	0
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death Month	h 3. Time of Death Day Year 1941 hrs	Ī
Medical Exami	ner	Ram Naga Rajan 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location	June 28, 2	4c. County of Death	_
		5300 Tuckerman Lane	Rockville		Montgomery	_
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 6. Sex 61	Months Days Hou	na Min	th(MM/DD/YYYY) 9. Birthplace (State or Foreign	
		076-50-9645 1⊠ м 2 F 61 N	frs.	Oct 6,	1948 Country) India	_
w any		10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits	
Maryland 28a-f show any d at once.	tor	MD Montgomery Potomac 10e. Street and Number	10f. Zip Code	I 10	Og. Citizen of What Country?	_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Director	8605 Aqueduct Road	20854		USA	
eath with items 2	Funeral	1 Never Married 2 X Married Armed Forces?	Was Decedent of Hispanic O f Yes, specify Cuban, Mexica		14. Race - American Indian, Black, White, etc.	
after de	by Fu	3 Widowed 4 Divorced If Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Together Yes 1	Yes 2 No specif	fy:	Specify: Indian	
hours 'natur	ted b	15. Decedent's Education (Specify only highest grade completed) 16a. Deced	ent's Usual Occupation (Given most of working life, DO NO		16b. Kind of Business/Industry	
136 thin 72 ne. than '	Completed	12 CPA			financial	
5-0 iled wi Hygie d other		17. Father's Name (First, Middle, Last)	18.Moth	er's Name (First, Middle, M	<i>'</i>	_
21215-0036 vold be filed within 7 Mental Hygiene, marked other than	o Be	V-Ramamurty 19a. Informant's Name/Relationship (Type, Print) 19b. Mail		nxa Devi Shan umber or Rural Route Num	nkar ber, City or Town, State, Zip Code)	=
MD and 2 show alth and m 27 is sumation			·		c, Maryland 20854	
or Heal		20a. Method of Disposition 20b. Place of Disposition Burial 2 Cremation 3 Removal from State	osition (Name of cemetery, other place)	Date	20c. Location - City or Town, State	
Baltimore, permit. Pages I ar Department of Her Important: If ite		4 X Donation 5 Other Specify:	Name and Address of Facil	lity		-
Ba perm Depa Impo injur		21. Signature of Funda Service Licensee 101	Baltimore, M	iÿ Board; 655 Taryland 2120	W. Baltimore Street	
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.	r the mode of dying, such as	cardiac or respiratory arre	est, shock, or heart Approximate Interva Between Onset and	
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Death	_
		Sequentially list conditions, b				_
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that inflated)			Solos	
rted d ansit	Exal	events resulting in death) Last Due to (or as a consequence of): d.				
50, te be executed nysician and burial - transit	edical	UNPENDED AMENDED				
Box 68760, edath certificate be the attending physic of for use as the bur	ıΣI	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ector	pic pregnancy	23d. Date of delivery Month Day Year	
30x 6876 death certificate e attending phy	sicia	past 12 months? 4 Pregnant at time of death 5	Other (Specify)	programay	Monar Bay 188	
O. Bc t the dea by the a	Phys	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in f	Part I. 23e. Did tot	bacco use contribute to the cause of death?	_
P.O. ires that 1 signed b	É		, , ,		2 No 3 Probably 4 Unknown	
Records, The law requir. Ticate has been so page 2 should t	Completed			24a. Was a autops	sy prior to completion of cause of	е
Reco	mo			perform 1 ✓ Yes 2		
Vital Rec ysician: The his certificate director, page	å	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatie	[] (Othor: [h (Check only one) Nursing Home 5	Residence 6 🗸 Other Scene	_
of Vital ling Physician After this cert funeral directo	٩	1 Yes 2 No Imparent 2 Errouspane 27. Manner of Death 28a Date of Injury 28b. Time of		ork? 28d. Describe h	low injury occurred	-
ion ttendin leath. tor: A	atio	1 Natural 5 Pending Jun 28, 2010 1800 hrs	1 Yes 2	✓ No Subject jump	oed to train tracks	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 V Suicide 6 Could not be determined (Specify) metro	eet, factory, office building,	or Town, St	treet and Number or Rural Route Number, City late) an Lane, Rockville, MD	/
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence (Check only one) 2 Medical Examiner: On the basis of examination and/or investig				
To the within To the complete	Medical	and manner stated. 29b. Signature and title of certifier	29c. License numbe		29d. Date signed (Month, Day, Year)	_
		auetz	O.C.M.E.		June 29, 2010	
	•	30. Name and address of person who completed cause of death (Item 23a)	Street Delivers Adv	D 21201		_
	ate	31 Date filed (Month, Day, Year) 32. Registrar's Signature	Street, Baltimore, MD	D 2 1201		_
Regist			arel !			
DHMH 17 Rev 1/2	001	OGME ORIGIN	AL			

nael Davon S		1- For State Certific			Mental Hy		20	10	21591
Physicia dical Exami	an/	1. Decedent's Name (First, Middle, Last) Michael Davon	_	Stone		2. Date of Deat Month July 8, 201	h Day Year		Time of Death
)		4a. Facility Name (if not institution, give street and number) Eastbound East Capital Street at Bugler Street		b. City, Town, or Lo		July 0, 20	4c. County of		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday) Yrs.		If Under 24Hrs. Hours Min.	-1	h(MM/DD/YYYY) -1982	9. Birthpla	ace (State or
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Locati						d. Inside City Limits
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ter death with ', or items 2	Funeral Director	11. Marrital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	If Y	s Decedent of Hispa es, specify Cuban, M Yes 2 💢 No	Mexican, Puerto F		14. Race - White,	etc.	Indian, Black,
3, MID 616 2-1030 and 2 should be filled within 72 hours after death with the Maryland seath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once.	ompleted by	or Dates:						iness/Indu	stry
Z I Z I 3-0030 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	omo	12th Grade 17. Father's Name (First, Middle, Last)		Waiter 118	.Mother's Name	First, Middle, N	Res	taur	ant
be filecantal Hyrked of	BeC	Michael Stone			Miche.	lle B	rooks		
MIC 6	۱۹	19a. Informant's Name/Relationship (Type, Print) Michelle D. Stone / Mother 5		Address (Street a					
E, IV	-	20a. Method of Disposition 20b. Place		tion (Name of ceme		Date	20c. Location - (
permit. Pages I a Department of He Important: If ite		1 / 2 Dullal 2 Cleffiation 3 Refiloval from State	ar H	ill Cem.			Suitl		
		21. Signature of Funeral Service Licensee OWW William MO 1182	Ho	ame and Address o	Georgi	a Āve,	NW/Wash	n., D	C 20011
Physician i Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do refailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	not enter th	e mode of dying, su	uch as cardiac or	respiratory arre	est, shock, or heal	t A	pproximate Interval Between Onset and Death
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rted d ansit	Examiner	cause. Enter Underlying Cause (Underday of highly that highlated events resulting in death) Last consequence of the consequence			_				
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ath certificate attending phys or use as the b	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	2 Fel	al death 3	Ectopic pregnan	icy	23d. Date of o	lelivery Day	Year
res that the d signed by the	by Phy	Part II. Other significant conditions contributing to death but not resulti	ng in the u	nderlying cause give	en in Part I.		bacco use contrib		cause of death?
Is to Attending Physician: The law require rs after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed					24a. Was a autop perfor	sy pr med? de		sy findings available pletion of cause of
cian: The certificate ector, page	Be Co	25. Was case referred to medical			f Death (Check o		2 10 1	V Tes	2 110
Physici r this c	To E	Tes 2 No	Outpatient				Residence 6		ene
tending Pleath.		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Jul 8, 2010 28b. Time of Injury 0106 hrs 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Driver in collision with support							е
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / H	Accident Investigation Suicide 6 Could not be determined determined (Specific) Major Panel / Highway Accident Investigation Suicide 6 Could not be determined determined (Specific) Major Panel / Highway (Speci						· ·
the Hos iin 24 h the Fun pletely	edical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, di Check only 2 Medical Examiner:On the basis of examination and/or							use(s)
To I with To I	Med	and manner stated. 29b. Separature and title of certifier		29c. License r			29d. Date signe		
ر م		30, Name and address of person who completed cause of death (Item 23a)		O.C.M	.E.		July 8, 2010)	
	- 1				ore, MD 2120				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:24PM Physician/ July 5. 2010 L. Stinson, Sr. 5:24 P. Medical 4a. Facility Name (if not institution, give street and number) c. County of Death Baltimore 4b. City, Town, or Location of Death **Examiner** Rosedale Franklin SquareHospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗒 F Months Days Hours April 3, 1931 2010 Marviand Director 212-28-6996 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Baltimore Parkville Maryland 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 3330 Willoughby Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White Frank If Yes, Give 1 Yes 2 XNo Specify: Specify: Completed 3 XXWidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Painter's Union Local 1 Painter Ingon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Catherine Warner Raymond Stinson injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is n any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Indian Echo Drive Jarrettsville MD 21084 Jacqueline Davis/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gardens of Faith 7/9/10 Baltimore Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Nams and Address of Facility Inc. 5305 Hartord Road' Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours a er death.

To the Funeral Director Affer this certificate has been signed by the atten completed filled in by the funeral director, page 2 should be deteched for an order of the complete of the co in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death
Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Ischemic 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Hospital: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 🖼No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending tal 2 Accident Juno 23 20 10 44 KnowVM Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 T. Lutherville, Md 21092 MD Lue Tw 31. Date filed (Month, Day, Year) 32. Re State Registrar

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21593 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2010 Year Ear1 Slater 27 8:00 A. M Medical 4a, Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 208 Long Cross Drive Road Anne Arundel Linthicum Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Virginia 1**X**□ M 2 □ F Months (Month, Day, Yea 1-19-192 Hours Min. Director 214-18-3652 Vre Usual Residence of Decedent 10a, State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 No MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code or than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 208 Longcross Road 21090 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1XX Yes 2 No 19
If Yes, Give 1 0 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1943 Baltimore, Maryland 21215-0036 1 Yes 2 x No Specify: Completed 3 Widowed 4 Divorced 1945 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Foreman Stee1 Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important; If item 27 is marked of any injury or other traumatic eve ဂ Benjamin Slater Sadie Haynie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Slater - wife 208 Longcross Rd., Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2XXCremation 3

Removal from State Atlantic Crematory 06-30-2010 4 ☐ Doration 5 ☐ Other (Specify) Glen Burnie. Sig e of F 22. Name and Address of Facility Gary L. Kaufman Funeral Home at neral Service L Inc., 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death ONGES disease or condition STHONTHS Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? been signed by the atte should be detached for Month Pregnant at time of death Dav Year Yes 2 Live g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed?

Yes 2 No seure mause 1 Yes 2 1 No To Be 25. Was case referred to examiner? filled in by the funeral director, 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier сопретер (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Bay, Year)

TTENDING

Please Type or Print in Black Indelible Ink /Ensure All Copies Are Legible.

AMEND TIEM#8PerFH, G905,7/16/2010, WS

State of Maryland / Department of Health and Mental Hygiene
AMEND TIEM#7perFH, G905,7/19/2010, WS

Certificate of Death

Reg. No. 26 | 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 5:30 AM Josephine Μ. Schatz 1014 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Square Hospital Center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1934 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗙 F 192-28-0109 Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c, City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If flean 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a health and injury or other traumatic event, it a health Expulse must be mathly any injury or other traumatic event, it as health as any injury or other traumatic event, it as health as a second any injury or other traumatic event, it is a second and in the second and it is a sec Director 1 TYes 2 X No Baltimore Baltimore Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8810 Walther Blvd. #3126 21234 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Dowling Greer McIlvain ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8810 Walther Blvd. #3126 Baltimore, Md. 21234 Mr. Robert Schatz/ Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Hillton Service Co. 7-16-10 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc 1050 York Rd. Towson, Md. 212 21. Signature of Meral Fervice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic /Medical Due to (or as a consequence of): Examiner Due to (r as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Renal Faylure and the Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 18 months? 1 ☐ Yes 2 Daylo Month Day Year 5 Other (specify) the detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 □Yes 2 🗷 No certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide McCrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 0 64 / 98 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11.10 JULY, 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD 21237 M.D. Kottorathil 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Dark JUL 12 2010 Registrar

DHMH 17 Rev 1/2001

Josephine

chatz,

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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tien Z7 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (S		Re		. Name and Addres					_		S
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89	ath certifica attending p I for use as t	اج ا	IF FEMALE: 23b. Was decedent pregnant		utcome of pregree Birth 2 🗆 Fe		Ectopic pregnanc	V			23d. Date of	f delive	ry	
ခြို	death e atte	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specify)	у			Month		Day Y	'ear
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σ.	igned be de	ğ	anconhalamt	Ins contributing to	. 0		LONDIO 1	v l Th	1 2		co use contribut			
rds	equire een s ould	eted	. The principle	The second	Muzik	,	· carrer	morr	T					
00	law n hasb e 2 st	Completed by	faille.	dicipl	les_				_ 2	24a. Was an autopsy performed	prior	to cor	sy findings a npletion of c	ause of
å å	cate pag		V							Yes 2		Yes	2 🗌 No	
<u> </u>	rsician; The law is certificate has bilirector, page 2 s	0	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	7	1	Othe	ace of Death (-		
<u></u>	rthis eral di	9: To	27. Manner of Death	28a. Dat	Inpatient 2 c	☐ ER/Outpatier 28b. Time of					e 6 Other (S	pecify)		
בֿ י	th. : Afte	cat	1 Natural 5 Pendin 2 Accident Investig	9 .	nth, Day, Year)	injury	work	? Yes 2 □ No			,,			
<u>isi</u>	or Attendi after death. Director; A in by the fu	Certificate:	3 Suicide 6 Could in 4 Homicide determ	ined 28e. Plac	e of Injury - At h		eet, factory, office				t and Number of	Rural	Route Numb	er,
<u>S</u> .	talor rsaft alDir ledin			Dulk	anig, etc. (Speci	· <i>y</i>)	,			ity or Town, St				8
Division of Vital Records, P.O. Box 68760	io the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical					occured at the time,							nner stated.
	the the omble	ğ	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner	: To the best of r	ny knowledge, o	death occurred at the		nd place, and		se(s) and manne Date signed (M			
	3 2 3) /0x0 /0cm	Vain	bon	mi	XXX	11.11	200	290.	Date signed in	D		
			30. Name and address of person v	who completed car	use of death (Ite	m 23a) (Type F	Print)	070	707	0 /				
	6		Varsho Unio	ilbar 7	5039	SILLYO	HE Rd	1110.	Hom	mo	120	72	5	
	Stat		31. Date filed Month Pay Year)	32.	Registrar's Sign	ature			,,,,,,,	, , , , , ,				
	Registra	ar	ANT TO CALL	Charles .	1. 18.	The Case of the Ca								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 5 9 6

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylar			te of L		vicillai i	Reg. No			
	Physici	an.	1. Decedent's Name (First, Middle, Last,						2. Date of Month	Death Day	y Year	3. Time of Death	
	/Medic	al	SARA TYBERG				T	Landing of Doorb	JULY	09	2010 County of Death	4:35 P M	
1	Examin	er	4a. Facility Name (If not institution, give KESWICK MULTI-CA			4b. City		Location of Death ALTIMORE		40.	N/A		
	Funeral Director		5. Social Security Number 6. Security 122–26–9940		last birthday) Yrs.		or 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Month. 08/04/	Birth (Pay Year)	9. Birth	place (State or Foreign intry) NY	
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State MD 10b. County BA	ALTIMORE 10c. Ci	ity, Town or Lo		BALTI	MORE				10d. Inside City Limits 1 ☐ Yes XX No	
	with the a or 28e	Funeral Director	10e. Street and Number	WE #400		10f. Z	ip Code	000		10g. Cit	tizen of What Cou	untry?	
	Jeath The 23	eral	1500 BEDFORD AVEN	12. Was Decedent Ever in L	J.S. 13. 1	Was Dece		208 spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or	No-	USA 14. Race - Amer		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturel", or Items 23s or 28s-f show mary injury or other traumatic event, the Medical Examical must be notified at another.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		lf Yes, spe 1 ☐ Yes		Specify:	Rican, etc.)		Black, White	o, etc. WHITE	
<u>5</u>	"natu	letec	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced	kind of w	uaf Occupa	tion uring most of wor	king	16b. K	ind of Business/I	ndustry	
212	d within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1		ORKER				CENSUS I	BUREAU	
밀	be filed ital Hygie of other event,	BeC	17. Father's Name (First, Middle, Last)	EIDE				18. Mother's Nam					
<u> </u>	should b nd Ment marked	٦		FIDEL	10h Mailte		/Ct4-	GOLDIE			.CMAN	in Code)	
	end 2 si salth an n 27 le r		19a. Informant's Name/Relationship (T) TOBI TYBERG/DAUGH		1000000	F.	Decre votes in the	ROAD, ER		0.50000		p code)	
ore,	es 1 e of Hea fitem r othe		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 🗆 F	20b.	Place of Dispo cemetery, crer	sition (Na natory or	ame of other place	,)	Date	20c. L	ocation - City or		
Baltimore,	t. Pages riment of rient: If it rieny or o		4 ☐ Donation 5 ☐ Other (Specify)	DE I	'H TFIL			07/12 s of FacilitySOL	/2010		TIMORE,		
Ba	permit. Depertr Importe eny Inj	, ,	21. Sign (ure) if Funeral Service Licens	of the								MD 21208	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ications that caused the dea ne cause on each line.	th. Do not ent	er the mo	de of dying	, such as cardiac	or respirator	y arrest,		Approximate Interval Between Onset and Death	
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Renal Fails Due to (or as a conse								المرادموس	
	Examiner		Sequentially list conditions			Fai	lune					Uniciana	
	ed sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a consequence of									
Ć.	tificate be executed g physicien and as the burlal-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):								
68760,	ate be hysicie	edical		d									
			IF FEMALE:	23c. If yes, outcome of pregn	ancv						23d. Date of deli	NAD.	
.o. Bo	the death cer y the attendin iched for use	by Physician/N	23b. Was decedent pregnant in the past 12 menths? 1							-	Month Day Year		
rds, P	The law requires that the death cer ate hes been signed by the attendir page 2 should be detached for use	ed by PI	Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contrib									-	
Division of Vital Records, P.O. Box		Completed							pe	fas an utopsy enformed s 2 No	prior to death?	topsy findings available completion of cause of	
/ita	iclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Jose Heli			104	26. Place of Dea					
on of	g Physier this	tlon: To	1 Yes 2 No 27. Manner of Death 1 Vatural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		28c. fnjury Work	4 Denuising I	ome 5 R		6 ☐Other (Speciary occurred	cify)	
Divisi	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fur	Certification:	3 Suicide 6 Could not be determined	reet, facto				on (Street and Number or Rural Route Number, Town, State)					
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in In	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the tim n, in my op	e, date and place inion, death occu	, and due to t rred at the tin	he cause(s ne, date an	and manner as d place, and due	stated. to the cause(s)	
	To the To the comp	×	29b. Signature and title of certifier			25	9c. License			29d. Da	ate signed (Monti	h, Day, Year)	
•	^		PUCY	MA			Doos	9056		7/	9/10		
	TN		30. Name and address of person who co				S+ B	cit Mo	212	11			
× 3	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are 2 (1) State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 116 .22 0 2010 06 /Medical County of Death acility Name (If not institution, give street and number 4b. City Town or Location of Death Examiner 8. Date of Birth (Month, Day,) March 9, 9. Birthplace (State or Foreign Number **Funeral** M 2DF Months Davs Hours 1938 Pennsylvania 72 202-30-0997 March Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 √ Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with USA 21215 4601 Pall Mall Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry uni 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Is marked other than factory worker unk iink 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be and Mental Zella Martin Oliver True 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any injury or other trains 10 N. Calvert St. Ste 300; Baltimore, MD 21202 Artie Shaw - guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☑Other (Specify)in State 21. Signature of Funcial Cervice Ricensee 22. Name and Address of Facility Board; 655 West Baltimore Street Baltimore, Maryland 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9☐Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 2 No certificate 1 TYes 1 2 HO Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 2 1 Inpatient this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a Date of Injury 28b. Time of 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? Certification: Division To the Hospital or Attending Natural (Month, Day Year) 5 Pending investigation М 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

IAOA 31. Date filed (Month, Day, -Year)

29b. Signature and title of certifier

8 2

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Delores рм Weaver 2010 30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Balto Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days 1 □ M 2 🛭 F Months Min. Hours 77 8-28-1932 Director 216-32-7785 MD Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 10d. Inside City Limits 1 Yes 2 □ No na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 123 W. 29th Street Apt 4 A 21218 U S Hygiene. other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 □ Divorced If Yes Give 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12 OTh grade College (1-4 or 5+) Housewife Home Health and Mental Hygie em 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John F. Jones, Sr Emmaline Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Grimes-Niece 3317 Lawnvie<u>w Avenue</u> Department of Health
Important: If item 2
any injury or other t Balto, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Carmel Cem 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7-10-2010 Balto, MD 4 Donation 5 Other (Specify) March 21. Signature of Funeral Service Licenses East F/H 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) UNC months Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any local sequentially cause. Enter Underlying Cause (Disease or iinjury Clay to for each consequence of: been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: A er this pertificate has page 2 autopsy performed? death? 1 Yes 2 No Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chayler SE TONSON MO

DHMH 17 Rev 7/2009

State Registrar 6701

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s Signature

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32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Town, or Location of Death 4b. City 4c. County of Death **Examiner B**a na If Under Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) S . C . **Funeral** 1 □ M 2🛣 F Months Hours Min. 9-5-1942 67 Director 5-46-6499 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d, Inside City Limits 10c. City. Town or Location the Medical Examiner must be notified at Director 1 🖺 Yes 2 🗌 No Baltimore na 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral items 23a 21225 U S Α 905 Bunche Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. . Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or à 1 Never Married 2 ☐ Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Black If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry na (Give kind of work done during most by working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) na na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Issom Wright Martha Marinev 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Williams-905 Bunche Road Balto, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Pk 7-13-2010 Randallstown, 4 Donation 5 Other (Specify) March East F/H Signature of Fun Service Licensee 22. Name and Address of Facility Brown Mr. Rin 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pmysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executifin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician an completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director. Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably ♣ Pnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 Division of Vital 26. Place of Death (Check only one) Be Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? Natural 5 Pending 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🖰 crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier License number 29d.

State Registrar

arks

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21600 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ J_{u}^{Month} 7, 2010 8:30 A M Kenneth Newcomer Weaver Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 🛛 M 2 □ F Days 1/16/1927 Pennsylvania 171-20-8261 83 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f sl edical Examiner must be notified 1 Yes 2 x No Maryland Baltimore Timonium 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21093 U.S.A. 2525 Pot Spring Road S 322 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Director of Maryland Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Geologist Geo Survey Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cora Newcomer Amos Ross Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Mary Elizabeth Weaver / Wife 2525 Pot Spring Road S 322, Timonium, Maryland Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv. Corp 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 7/9/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) mensha Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury ending physician and use as the burlal-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical トピルハダイ Webyer Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy cate has been signed by the atter page 2 should be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Month Day Vear Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Hospital or Attending Physician: The Yes 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence ၀ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print)

Registrar

RNP

32. Registrar's Signature

Timonium MA

		-	1- State of Marylar		artment of Healt		ntal Hygie		21601
			Decedent's Name (First, Middle, Last)			2.	Date of Death	Day Year	3. Time of Death
	Physicia /Medic	na I	Martha Webb				une	28, 2010	11 pu
	Examin		4a. Facility Name (If not institution, give street and number)	C	4b. City, Town, or Loca	ition of Death		Anne A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.				Data of Righ	0 Birt	hplace (State or Foreign
ı	Funeral Director		093.22.1073 10M 20/F	85 Yrs.	Months Days Ho	ours Min.	(Month, Day, Ye	\$25 Nort	h Carolina
	put &		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ty, Town or Lo	ecation				10d. Inside City Limits
	daryla f shov	ō		ckeysv					1 ☐ Yes 2 ☑ No
	r 28a-	Irect	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Co	ountry?
	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show dreal Examiner must be rediffed at	Funeral Director	10815 Powers Avenue		21030			USA	
	er dea tems	nuel	11. Marital Status 12. Was Decedent Ever in U	.S. 13.1	Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specif exican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	
36	irs aft		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No Spe	ecify:		Specify: b	Lack
21215-0036	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	168	b. Kind of Business	/Industry
21	vithin ne. hen "	mple	Elementary/Secondary (0-12) College (1-4or 5+) 1 2 0	LP			E	healthca	re
2	filed v Hygie Ither t	Be Completed by	17. Father's Name (First, Middle, Last)	DI		Mother's Name (F	irst, Middle, Mai		
an	lid be fental rked o	To B	Shepard Carmichael			Ella Arm	strong		
Maryland	od 2 shouth and M		19a. Informant's Name/Relationship (Type, Print) William Carmichael - nephew	19b. Mailir 10	ng Address <i>(Street and N</i> 9 Versaille	Number or Rural F Cir; To	Route Number, C WSON, Ma	aryland 2	Zip Code) 1204
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturely, or Items 23e or 28a-f show any injury or other traumatic event, the Middeal Examiner must be notified at any injury or other traumatic event, the Middeal Examiner must be notified at ange.		20a. Method of Disposition 20b. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Constion 5 ☑ Other (Specify)	Place of Dispo cemetery, crea	osition (Name of matory or other place)	Date	9 200	c. Location - City or	Town, State
Baltir	permit. P Departme Importen any injur		21. Signature of Fureral Service Licensee at 1e1 A Nay Or	22	2. Name and Address of State Anat			W. Baltim	ore Street
			23a. Part1. Enter the disease, or complications that caused the dea	th. Do not en	Baltimore, ter the mode of dying, su	Mary Lan ch as cardiac or r	espiratory arrest	1	Approximate Interval Between
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	3	URASERS	75			Onset and Death
	/Medical		resulting in death) a Due to (or as a conse	quence of):	+30				
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to irr as a conse	TITO TO	tareco	il 11	-11/6		
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	delle i	tailor	c X	Ch 18	3	
Ć	sician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a conse	quence of):	, ,	A	2 / - /	_	
3760	# % #	cal	d. 1257/AZ	the	reuse	416	ula		
x 68	eath certificat attending phy I for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregr	ancy				23d. Date of de	liven
Вох	attend for us	clan	in the past 12 months?	al death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
o.	that the de led by the a detached f	hysl	1 Yes 2 No 9 Unknown				T		
S, D	as gr	by	Part II. Other significant conditions contributing to death but not to	Sulting in the U	underlying cause given in	Part I.	23e. Did toba		robably 4 Unknown
Records,	w requir been si should I	Completed	Cerupe Chase It	PAM	Rito Isla	intes	24a. Was an		utopsy findings available
Rec	The law aate has I page 2 s	ldm	Dispersion 1	1/10	II A DI	ANTO	autopsy performe	prior to death?	completion of cause of
Vital		0	25. Was case referred to medical	as	26.	Place of Path			5 2 1140
fVi	ys dis	To B		☐ ER/Outpatie	nt 3 DOA Other: 4	Nursing Home	e 5 🗆 Residen	ce 6 □Other (Sp	ecify)
n of		1.	27. Manner of Death 1	28b. Time of Injury	Work?	28 2 🗆 No	d. Describe how	injury occurred	
Division	at at	icat	2 Accident investigation 3 Suicide 6 Could not be determined by the Suicide 28e. Place of Injury - At	home, farm, s					Rural Route Number,
Div	al or A s after I Dirac	Certification:	4 Homicide determined building, etc. (Spec	ify)			City or Town,	State)	
	To the Hospital or Atter within 24 hours after de To the Funeral Diracto completely filled in by th	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, dea nation and/or in	th occurred at the time, d nvestigation, in my opinio	date and place, an on, death occurred	d due to the cau d at the time, dat	use(s) and manner a e and place, and du	as stated. ue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License nui	mber	290	d. Date signed (Moi	oth, Day, Year)
•			I della fortill		4184	26	1	Non	y010
	*****		30. Name and address of person who completed cause of death (Its	m 23a) (Type	Print) POTES	- ST. E	AUT. N	NE 20-	25
	Sta	ate	31. Date filed (Month, Day, Year) 3 Registrar's Sign	nature					
	Regist	rar	JUL 122010 Centra 1	1. 40	Will and the second				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:15P M Theresa C. Wright UNE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Lanham Dcotors Community Hospital 8. Date of Birth 9. Birthplace (State or Foreign April 1938 Mary 1 and 1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 1 M 2 X F Days Min Hours Director 577-50-1242 72 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Prince Georges Landover 1 Yes 2X No ō 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? items 23a Funeral 1114 Hill Road 20785 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ō ģ 1 Never Married 2 Married Maryland 21215-0036 Specify: black 1 ☐ Yes 2 No Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) caregiver childcare Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Time Norris Sarah Chase WRESKT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Chase - cousin 6801 Bock Road #247; Ft. Washington, MD 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) in State 21. Signature of Every Service Licensee Naule Nayl ^{22.} State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the complex line.

Immediate Cause (Final Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine signed by the attending physician and the detached for use as the bunal-transit Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the orderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown s been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No ၉ 1 Yes 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury Natural Accident 5 Pending (Month, Day, Year) work death. M 1 Yes 2 No Investigation 24 hours after death e Funeral Director: To the Hospital or Atter within 24 hours after der To the Funeral Director completed filled in by th 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one signed (Month, 29c. License numbe

State Registrar Registrar's Signa

M 1) 20106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 | 0 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 2010 8:40 AM Walter Vernon Ailstock Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Center Towson 9. Birthplace (State or Foreign Country) W. Va. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 ☑ M 2 ☐ F Months Hours Min. Oct. 14, Year) Director 289-22-7897 84 Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits 10c. City, Town or Location must be notified at Directo 1 ☐ Yes 2 No MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 21042 4628 Broken Lute Way 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married ō ☐ Yes 2 X No filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Government Printer Linotype Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Ailstock Linnie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 7500 Shadowridge Run Unit 36, Austin, TX 78749 Betty O'Rourke / Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Ardent Cremation June 26, 2010 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01411 Harry H. Witzke's Family FH, Inc or t 4112 Old Columbia Pike. Ellicott City Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final h sician/ rumm disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate Examine Due to jor as a consequence of if any leading to immedicause. Enter Underlying physician and the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending plate as t IF FEMALE been signed by the attendin should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy death? 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, **Division of Vital** 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 🕦 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hou To the Funer completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Registrar DHMH 17 Rev 7/2009

State

29b. Signatuj

31. Date filed (Month, Day, Year)

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d at the time, data and place, and due to the

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Cartifying Nurse Practionar: To the best of my knowledge, death or

MIRS

UNS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of M	-	epartment of Certificate o				ien 201	0 21	604
			Decedent's Name (First, Middle, La	st)					Date of Deat			me of Death
	Physici		Michael Li	inn A	Iderso				Month inne		ear	2 43 M
March.	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town	or Location	of Death	<i>y- (i)</i> <u>C</u>	4c. County of		
	Examin	E	VA Lochraven Com			Baltin	nore					
Ť	Funeral		5. Social Security Number 6. S	iex 7. Ag	je (In yrs. last birti	nday) If Under 1 Yea	r If Under	24 Hrs. 8.	Date of Birth	(Vear)	I. Birthplace (S Country)	tate or Foreign
	Director		587-52-8903	⊠ M 2□ F	59	rs. Months Day	s Hours	Min. De	(Month, Day,	1950		linois
	ס		Usual Residence of Decedent									
	rylan how	_	10a. State 10b. County		10c. City, Town	or Location						de City Limits
	e Ma Sa-f s	cto	MD Howar	1	Elkrid	ge						Yes 2 TxNo
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code)		1	0g. Citizen of Wha	at Country?	
	th wi	la l	6122 Old Washin	gton Road	#2	21075				United	States	
	r dea	nu	11. Marital Status	12. Was Decedent Armed Forces?)	13. Was Decedent o	f Hispanic Or Jban, Mexica	rigin? (Specify n, Puerto Rica	Yes or No- an, etc.)		American India White, etc.	an,
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Wedical Examiner must be positified at	y F	1 ☐ Never Married 2 ☐ Married	1 Tyyes 2 ☐ If Yes, Give	No Vietnam	1 □Yes 2 🖫 N				Specify:	W	hite
21215-0036	ural"	Completed by	3 ☐ Widowed 4 🙀 Divorced	real of Dates.						405 Kind of Bush	ana (Industry	
7	"nat	lete	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Decedent's Usual Oco (Give kind of work dor life. DO NOT use reti	ne during mos	st of working	1	16b. Kind of Busin	less/industry	
72	vithin	ם	Elementary/Secondary (0-12)	College (1-4or	5+)		,			Comata	tion	
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Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, It. W. doal Exa.	Be	Donald Alderson				Į		_	e Hamner		
Ĕ	d Me d Me nark natic	ျှ		Time (Print)	10h	Mailing Address (Stre					tate Zin Code)	
Ma	d2sl than 7 Isr		19a. Informant's Name/Relationship			22 Old Was						
e)	permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any Injury or other trae		Russell Alderso: 20a. Method of Disposition	n/Son		Disposition (Name of	1	Date		20c. Location - Ci		ate
Baltimore,	iges nt of if it		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemeter	, crematory or other p						
ŧπ	t. Pa ntmer ntant njury		4 ☐ Donation 5 ☐ Other (Special			ncoln Crem	-			Brentwo	od, Mar	yrand
Bal	Department of the popular of the pop		21. Signature of Funeral Service Lice	isee	M01463	22. Name and Add			-	ribute	D 20053	•
	40 = 6 Q		100							ville, M		
			23a. Part 1. Enter the disease, or com shock, of heart failure. List only	one cause on each I	ine.			1		rest,	Interva	ximate al Between and Death
· Sec	Physician		Immediate Courle (Fin 1) disease or condition	a Per	tasta 1	rc Lui	19 C	ance	1			
1	/Medical		resulting in death)	Due to (or as	a consequence of	f):	1					
	Examiner	L	Sequentially list conditions,	b								
_	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	f):						
5	ecut and -tran	Хап	that initiated events resulting in death) Last	C	a consequence o	fi.						
60,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ē		Due to (or as	a consequence c	·/·						
8760,	cate physi the t	dical		d								
9	eath certific attending p for use as	Me	IF FEMALE:	One If we externe								
Box	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 🔲 Ectopic pregna				23d. Date Mont	_	Year
Ö	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant : 9 ☐ Unknown	at time of death	5 ☐ Other (specify,						
σ.	that the de ned by the detached	F)	Part II. Other significant conditions	contributing to death l	out not resulting in	the underlying cause	niven in Part		23e. Did to	bacco use contrib	ute to the caus	se of death?
Records,	iires tha signed d be det		Part II. Other significant conditions	contributing to death i	out not resulting in	the underlying cause	giverimitari	"	1 DXY		☐ Probably	
010	w requir s been s should	Completed by						— ļ	19			
ec	e law has b	ed.							24a. Was a autop:	sv pri	ere autopsy fin or to completio	dings available on of cause of
	The	5							perfor 1 □ Yes		ath? □Yes 2□N	lo
of Vital	Physiclan: r this certific ral director, I	Be (25. Was case referred to medical examiner?					e of Death (C	heck only or	ne)		
<u></u>	hysio his o I dire	ှင	1 Yes 2 No			patient 3 ☐ DOA	Other: 4 X	lursing Home	5 🗌 Resid	ence 6 Other	(Specify)	
n o	ding Physiclan: The I h. After this certificate ha funeral director, page	ü	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Inj (Month, Da	ury 28b. T ay, Year) Ir	jury V	njury at /ork?		. Describe h	ow injury occurred	i	
<u>Si</u>	endi sath. or: A the fu	ati	2 Accident investigatio				□Yes 2□]No				
Division	ter de	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In building, e	jury - At home, far tc. <i>(Specify)</i>	m, street, factory, offic	e	28f.	Location (S City or Tow	itreet and Number n, State)	or Rural Route	e Number,
	ital o irs af ral Di	Ö		le .								
	Hosp 4 hou unel ely fil	cal	(Check only 2 Medical Exa	nysician: To the best miner: On the basis	t of my knowledge of examination an	, death occurred at the d/or investigation, in m	e time, date a ly opinion, de	and place, and eath occurred	d due to the at the time,	cause(s) and man date and place, ar	ner as stated. Id due to the ca	ause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	one)	and magners	tated.							
	To with	2	29b. Signature and title of certifier	11.		29c. Lice	ense number		'	∠⊌a. ⊔ate signed	монт, рау, Ү	cdi)
	MA		Albra lale	Illem	100	1/2	31/6	//		6/21/1	0	
			30. Name and address of person who	completed cause of	death (Item 23a) (Type, Print)	10		Di.	1 2 1	L 171	
			Ç-10-	HEIMER	170	29c. Lice D 2 Type, Print) 3 90 0 40	ChK	aven	DIVO	Da / Je	0,110	51518
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	a Kad.						
	Registr	ar	JUN 25 201	1 Duran	1 13.14	Mari						

		For State Registrar	State of M	laryland / Depa <i>Cel</i>	artment of H	lealth and N Death		ier 2 0	0 21605
	d.	1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month		3. Time of Death
Physicia /Medic	_		Aguila				6	24 20 4c. County of	9:50p ^M
Examin	er	4e. Facility Name (If not institution, give		-)	_	r Location of Death	1	Montgo	
Europol		19406 Penrod T 5. Social Security Number 6. S	9x 7. A	ge (In yrs. last birthday)	Germant If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplece (State or Foreign Country)
Funeral Director		551-35-9939	□M 2 X F	74 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 12-28-1	935	Philippines
puq		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
Maryle f sho	ō	FL Escambia		Pensaco1	а				1 ☐ Yes 2 No
r 28a-	rect	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Country?
th with 23a o	Funeral Director	6077 Strickland P	lace		32506			U.S.A.	
tems	uner	11. Marital Status	12. Was Deceden Armed Forces	?	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American Indian, k, White, etc.
is after	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 € If Yes, Give Year or Dates		1 ☐ Yes 2 🗓 No	Specify:		Specify	Asian
iled within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. After than "natural", or items 23e or 28e-1 show ont, the Madical Exercitiver mant be medified.	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occup	pation during most of wor		16b. Kind of Bu	siness/Industry
ithin 7 ithin 7 ithin 7 ithin 1.	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	kind of work done DO NOT use retired				
iled wi tygien her th		17. Father's Name (First, Middle, Last,	4	Age	nt Broke		ne (First, Middle,	Real Es Maiden Sumam	
yiding	o Be	Pedro Asis				Julita	a Dimaano		
# SEEE	오	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street				State, Zip Code)
and 2 st and 2 st eatth and n 27 is n		Mylena J. Truesda	le-Daught		Furlong	Way, Ger			
Dalltimore, permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 2000.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Stat	20b. Place of Dispo cemetery, cre Arlington	matory or other plai	ce)		Arlingt	City or Town, State
Saltimor Demit. Pages Department of mportant: If it any injury or o		' 4 □Donation 5 □ Other (Specif			2. Name and Addre				
Dan permii Depar Impo		21. Signature of Funeral Service Live	10. 4.00		308 Back				
		23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caus	ed the death. Do not en					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		II Bladde	- CA W	ith met	asheses		Onset and Death
/Medical Examiner		resulting in death)		as a consequence of):					
LAditities	70	Sequentially list conditions, if any, leading to immediate	b. Quella for a	is a consequence of).					
uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		,					
be executed be executed ician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or a	as a consequence of):					
68 / 60, ificate be executed g physician and as the burial-transit	lcal		d						
beath certificate attending physe for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcom	ne of pregnancy				23d, Dal	te of delivery
Boath cattern atten	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	1 Live birth	2 Fetal death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	:у		Мо	
ache ache	hysi	9 Unknown	9□ Unknown		-		-		
S, P	ру Р	Part II. Other significant conditions	contributing to death	but not resulting in the i	underlying cause gr	ven in Part I.		ibacco use cont ′es 2□No	ribute to the cause of death? 3 Probably 4 Unknown
nee linot	eted								
has has	Completed							med2	Were autopsy findings available prior to completion of cause of death?
VICAL MICIAL: The certificate hir rector, page	e Co	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only o	J C. 1.10	1 Yes 2 No
99	0 0	examiner? 1 Yes 2 No	Hospital: 1 Inpa	itient 2 ER/Outpatie	nt 3 DOA		Home 5 ☐ Resid		er (Specify)
	on; T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Ir (Month, I	njury 28b. Time o Da <i>y Year)</i> Injury	Wo	ork?	28d. Describe h	now injury occur	red
ISIO ktendii death. ctor: A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be		laiur. At hama farm e]Yes 2□No	28f Location (5	Street and Numb	per or Rural Route Number,
DIVISION I or Attending after death. Director: After	Certification;	4 Homicide determined	building,	Injury - At home, farm, si etc. (Specify)	reet, ractory, office		City or Tox		
pite ours ierel		29a. Certifier 1 ☐ Certifying P	nysician: To the be	st of my knowledge, dea	th occurred at the t	ime, date and plac	e, and due to the	cause(s) and ma	anner as stated.
- LV - 0	edical	one)	and manner	of examination and/or is stated.					
To the within 2 To the complet	Σ	29b. Signature and title of certifier				se number		-	d (Month, Day, Year)
		30. Name and ad ress of person who	and plated assure	f death (Item 22-) (Tre-	D3	1142		6-29	- 2010
8		G. Coleman				ockville	MD 20	850	
Sta		31. Date filed (Month, Day, Year)		strar's Signature					
Regist	car	. JUNEX M ZUIV /	BULLIAN DI	A PARTY OF THE PAR					

State Registrar 31. Date filed (Month, Day, Year)
JUN 2 9 2010

29b. Signature and title of certifier

oveer

(Check only one)

Loveen J. Puthumana 3110 Grace Field Rd 31 Iverspring, mD 20904 32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Year Physician/ JULY ALEXANDER, SR. ROBERT FRANKLIN 10:35a ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice of Oueen Anne's Centreville Oueen Anne's Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year, 1 🔀 M 2 🗆 F 220-32-9303 **Director** 76 Marvland Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No MD Queen Anne's Sudlersville 10e. Street and Number 10g. Citizen of What Country? Funeral 6209 Sudlersville Rd. 21668 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 Divorced 4 Divorced Year or Dates er than "nature the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Crane Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ David Alexander, Sr. Myrtle Burris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21668 Department of Health Important: If item 27 any injury or other the once. Judith L. Alexander (daughter) 6209 Sudlersville Rd, Sudlersville MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kent Cremation 7/6/10 Smyrna, DE. 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech M00510 West Cross st Galena le disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it failure. List only one cause on each line. Part 1. Enter the shock, or hear Immediate Cause (Final disease or dition Onset and Death Ph sician/ LUNG CANCER Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or es e consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospice 2 No Hospital Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred fter death. irector: After t Natural 5 Pending 2 No 1 Tes Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature d title of certifie

Registrar
DHMH 17 Rev 7/2009

DIL

State

Teal

Dr.

8221

Registr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith,

David H.

31. Date filed (Month, Day,

D39887

Suite 302 Easton, MD.

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Eugene Allen 6:33 Am Charles JUIV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Northampton Manor Nursing Center . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth Year) **Funeral** (Month, Day Days Hours 1 1 M 2 □ F 68 Mary land 134-32-0753 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and if and T27 is marked than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick 1 X Yes 2 ☐ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 326 Selwyn Drive, Apt. 2A U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 \square Never Married 2 \square Married Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify: Black 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Director of Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Allen Frances Riddick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
326 Selwyn Drive, Apt. 2A, Frederick, MD 21701 Mrs. Daisy Clarke, PR Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State permit. Page Department o Important: If any injury or once. Smithsburg Crematory July 7,2010 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Keeney & Bastord P.A. Funeral Home M00255 106 East Church St. Frederick, Maryland 23a. Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

From Euneral Director: After this conflictor. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2: No 2 🗆 No 1 Tes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43091 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saeed A. Zaidi, M.D., 801 Tollhouse Ave, E-1, Frederick, Maryland 21701-6111

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ p^{M} 4:15 2010 Philip G. Byrnes June Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Morningside House Howard Ellicott City . Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Min. **№** М 2 🗆 F Hours (Month, Day, Year) 01/19/1928 022-20-9569 Director 82 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 No Milton MA Norfolk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 02186 242 Thacher Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. ₩ Yes 2 □ No 1946-1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 No Specify White Specify: 3 Widowed 4 X Divorced 1947 Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Post Office Postal Employee Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Smith Edward Jerome Byrnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11960 Little Patuxent Parkway Columbia, MD 21044 Eileen Fox - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/25/2010 Knollwood Mem. Park Canton, MA 4 ☐ Donation 5 ☐ Other (Specify, 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 21. Sign ur of Funcial Service Licen 4112 Old Columbia Pike Ellicott City, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death ☐ Pregnam. ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown icate has been sig ; page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No certificate Yes -25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: To Other (Specify) eral Director; After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 \square Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific M D es of person who completed cause of death (Item 23a) (Type, Print) (dubia 103 633 Date filed (Month.) Begistrar's Signature State

Registrar

name Known to Physician; Busby, Louis Joseph

			For State of M	aryland / Departmen		/lental Hygien	e 2010	21610
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate	e of Death	Reg. N	102010	3. Time of Death
	Physicia Medio		Louis Joseph Busby	y. Sr.			Day Jolo	2:35pm
,	Examin	er	4a. Facility Name (if not institution, give street and number)		Town, or Location of Death		4c. County of Death	
446	Funeral			e (In yrs. last birthday) If Under	1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthr	place (State or Foreign
	Director		007-26-8585 1 ₹ M 2 □ F	88 Yrs. Months	Days Hours Min.	Jan. 10 Year	922 °A1	abama
	and show	ř	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location			1	10d. Inside City Limits
	Maryl 28a-f otifie	Director	Maryland Cecil		Deposit			1 🗌 Yes 2 💢 No
	iid be filed within 72 hours after death with the Maryland Mental Hygiene. narked other than "natural", or items 23a or 28a-f show latic event, the Mydral Examiner must be notified at		10e. Street and Number 417 Craigtown Road	10f. Zip	21904	10g. (Citizen of What Cour	*
	items	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?		ent of Hispanic Origin? (Speif) ify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ	
36	al", or	Completed by	1 Never Married 2 Married 1 Y Yes 2 1 If Yes, Give Year or Dates.	No -	2 No Specify:		Specify: Wh	
Maryland 21215-0036	2 hours "natur dical I	plete	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usua	al Occupation of done during most of work		Kind of Business Inc	dustry
12/	ithin 7% ene. r than the M	Com	Elementary/Seconday (0-12) College (1-4 or 5 Eight Years	ife. DO NOT use	retired) ce Agent	G.1	E.I.C.O. erdeen, Ma	anuland
nd 2	filed wall Hygi	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maide	en Surname)	i y i u i u
yla	2 should be fil th and Mental 27 is marked traumatic ev	잍	James Busby			Eleanor St		
	sh har 7 is trau		19a. Informant's Name/Relationship (Type, Print) Jeanne M. Busby Gunn (daug		(Street and Number or Rura ter Road, Hav			
Baltimore,	Page 1 and 2 ment of Healt tant: If item 2 jury or other t		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Namcemetery, crematory or of R.A.Ferris &	ther place)	20c Wes	Location - City or To St Chester Pennsylv	own, State Cania
Balt	permit, Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses	n Sc. Lee e ama an	dedtterson & Perryville. N	Son Funera Maryland 2	11 Home, [21903-0766	P.A.
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cau le on each line Immediate Cause (Final	the death. Do not enter the mode	e of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
đ	Physician/ Medical		disease or condition	a consequence f):	LIAI INTO	arction		
	Examiner	er	Sequentially list conditions, b. Cost	rointesting	al Bleed	ing		
В	ted nsit	Examin	cause. Enter Underlying Cause (Disease or iinjury	a consequence of):		_		
	cate be executed physician and s the burial-transit	al Ex	that initiated events resulting in death) Last C. Due to (or as	a consequence of):				
092	physici the bu	edical	d					
. Box 687	th certifi ttending or use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 │ Yes 2 │ No 9 │ Unknown 23c. If yes, outcome 1 │ Live Birth 4 │ Pregnant a 9 │ Unknown	2 ☐ Fetal death 3 ☐ Ectopic p			23d. Date of delive Month	ery Day Year
P.0	that the desined by the a	by Pr	Part II. Other significant conditions contributing to death b	ut not resulting in the underlying o	cause given in Part I.	23e. Did tobacco	o use contribute to the	he cause of death?
rds,	equires een sig nould b	eted						bably 4 Unknown
Division of Vital Records,	sician: The law requires that certificate has been signed rector, page 2 should be de	Completed				24a. Was an autopsy performed?	prior to co death?	psy findings available impletion of cause of 2 No
ital	ysician: is certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Proposition		26. Place of Death (Chec			
of V	g Physer this	te: To	27. Manner of Death 28a. Date of inju	ent 2 ER/Outpatient 3 DC ry 28b. Time of injury 2	OA 4 □ Nursing Ho 8c. Injury at work?	ome 5 Residence 28d. Describe how inj		
ion	r Attending F er death. rector: After t by the furers	Certificate:	2 Accident Investigation	М	1 🗌 Yes 2 🗌 No			
Divis	al or Atsacre		4 Homicide determined 286. Place of Injurbuilding, etc.	ury - At home, farm, street, factory c. (Specify)	v, office	28f. Location (Street a City or Town, Sta		l Route Number,
_	To the Hospital or Attending Physician: within 24 hours a ler death. To the Funeral Director Affer this certific completed filled in by the fureral director.	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practioner: To the	xamination and/or investigation, in	my opinion, death occurred a	t the time, date and pla	ice, and due to the ca	use(s) and manner stated.
	Vith Vith Com		29b. Signature and title of certifier		. License number	29d. [Date signed (Month,	_
)		30. Name and address of person who completed cause of d		1-15628			2010
(6+IVA		Dr. CARDLINA CUSTODIC		d Health C	ure syst	m Perry Pa	int, MD 2 960
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 9 2010 32. Registre	ar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 рм Kim J. Baccaglini June 2:03 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice Center 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Country)Scotland Hours 1 □ M 2 🔀 F 0872971953 56 Director 082-48-3461 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Columbia Howard MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 21045 6168 Majors Lane . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2X Married Completed by 1 Yes 2 X No Maryland 21215-0036 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Human Resource Coordinator Engineering permit. Page 1 and 2 should be filed within Department of Health and Mental Hyglene Important: If item 27 is marked other the amy injury or other traumatic event, the onee. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Elizabeth Hendry John Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Columbia, MD 6168 Majors Lane Gene Baccaglini - husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 06/27/2010 Hanover, MD 4 Donation 5 Other (Specify) Ardent Crematory 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. Andre of Funeral Service Licer M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACCINCAT LINOMA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Taun to for as a ponsucuence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atten d be detached for us in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No BACCAGLIUI, Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 2 X-No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 I After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certifie

State Registrar

2010

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6701 N

egistrar's Signature

CHARLES ST, SUITE 405 BALTIMOREIMO 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 gy June 20 1ª0 James Butler 2231 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Hours Dec 12 ear 1967 Marwland 213-86-8319 42 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryl and Baltimore Baltimore 1 Tyes 2 XNo 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 1010 Alexander Ave 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. ģ 1 XNever Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: Black Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Landscaping 12th 0 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Butler Sr Yvonne Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Jones (Mother) 1010 Alexander Ave Catonsville, Md. 21228 Baltimore, 20a. Method of Disposition 20b Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State Memorial Gardens 6-26-10 Annapolis, Md. 4 Donation 5 Other (Specify) Mame Reaches of Recility Ons Mortuary, P.A. . Signature of Funeral Service Licensee 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lavo 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Month Day Vear Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by phciency 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen (24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifies completed filled in by the funeral director, t 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 X No 잍 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **≯** Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 243725

DHMH 17 Rev 7/2009

State

Registrar

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Rid

Westminister

MD21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHMOOD

JUN 2 4 2010

31. Date filed (Month, Day, Year)

		1	State	laryland / Dep	eartment of H Artificate of D			ene 2010	21613
		,	Registrar Amend#26 PerPhys PCT6-29- 1. Decedent's Name (First, Middle, Last)	-IUCF			2. Date of Death Month		3. Time of Death
	Physicia Medic	al .	William Merida Bradshaw, S	Sr.			June	24 2010	8:00 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 10741 Fingerboard Road		4b. City, Town, or Ijams			4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth	g. Bi	thplace (State or Foreign
Н	Director		577-54-9598 1™ 2□F	68 Yrs.	MONETS Days	Hours Will.	Month, Day, 7/16/1	1941 Was	hington, DC
	and show at	. h	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Le	ocation				10d. Inside City Limits
	Maryle 28a-f	irect	FL Po1k	Davenpo	rt				1 ☐ Yes 2 ☑ No
	th the	al D	10e. Street and Number 140 Allison Ave		10f. Zip Code 3389	7	11	0g. Citizen of What C	
	ath wi	Funeral Director	11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
ထ္ထ	fter de	þ	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X		If Yes, specify Cubar 1 ☐ Yes 2 ☒ No		Rican, etc.)	Black, White	te, etc. White
Ö	ours a atural' sal Ex	Completed	3 Widowed 4 Divorced Year or Dates.	16a Dece	edent's Usual Occupa			16b. Kind of Business	
215	n 72 h s. an "na Medio	ğ	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or a	(Give	e kind of work done d DO NOT use retired)		ing		
2	ygiene ygiene her th rt, the		12	Eleva	ator Const			Constructi	lon
and	oe filec intal H ced ot ced ot	To Be	17. Father's Name (First, Middle, Last) Kermit Littleton Bradshaw			18. Mother's Name			
Maryland 21215-0036	nd Me		19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street a			City or Town, State, Z	ip Code)
Σ	ealth a m 27 is ner tra		Gerry G. Bradshaw / Wife	140 4	Allison Av	e., Dave			
ore	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State		ematory or other place	e)	-	20c. Location - City o	
Baltimore,	iit. Pagartmen ortant: injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		coln Cemet			Brentwood,	
Ba	Depti Impo	.	174 Constance Yass	//		-			Le, MD 20781
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin	ed the death. Do not en	ter the mode of dying	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as	a consequence of):					
	cuted ind transit	Examiner	Cause (Disease or injury that initiated events	a consequence of:					
	res that the death certificate be executed signed by the attending physician and if be detached for use as the burial-transit	edical E	resulting in death) Last Due to (or as	a consequence of);					
3760	ficate I g phys	/edic	d						
39 ×	h certii tendin r use a	an/N		2 Fetal death 3	Ectopic pregnanc	·y		23d. Date of d	elivery Day Year
Bo	e deatl the atl	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown		Other (specify)			Month	Day Teal
<u>о</u> .	that th	by Ph	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	pacco use contribute t	to the cause of death?
ds,	requires been sign should be	ted b					1 🗆 Ye	es 2 🗆 No 3	Probably 4 D Unknown
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Re	ician: The law certificate has rector, page 2 s		25. Was case referred to medical		oc Bi	ace of Death (Chec	perform		es 2 No
Division of Vital Records, P.O. Box 687	ysician: s certific director,	To Be	examiner? Hospital:	tient 2 ER/Outpati	_ Othe			ence 6 X Other (Spe	Second ecify) Residence
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ion	ttendi death. :tor: A / the fu	Certificate:	2 Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	njury - At home, farm, s		Yes 2 ☐ No	28f Location (St	reet and Number or R	ural Route Number
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_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Medical	29a. Certifier (Check (examination and/or inve	estigation, in my opinio	on, death occurred a	t the time, date an	d place, and due to the	e cause(s) and manner stated.
	othe Prithin 2 othe Pomplei	M	only one) 3 Certifying Nurse Practioner: To the	e best of my knowledge	e, death occurred at the	e time, date and pla	ce, and due to the	cause(s) and manner a 9d. Date signed (Mon	s stated.
	F S F O		Dero four		D6	8104		6/25	110
?	11		30. Name and address of person who completed cause of		, Print)	inv n	W 312	702	
	Sta	e.	Eric Bushmi), Skoto 31. Date filed (Month, Day, Year) 32. Regist	ear's Signature	Freder	ICAN	1D 21	101	
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			State of Maryland / Dep			Mental Hyg	giene 2010	21614
			Registrar Ameno#8.Peni HPGC6-30-10cm Ce	rtificate of D	eath	T	leg. 140.	
	Physicia		Decedent's Name (First, Middle, Last) ARCHIBALD NII AMUKWEI BRUCE-QUA	YE		2. Date of Dea Month JUNE	24 20TC	3. Time of Death 1645 p M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or L	Location of Death	1	4c. County of Dea	
			Prince Georges Hospital	Cheverly			Prince G	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8, Date of Birth	3/27/1990 9. Bit	thplace (State or Foreign
	Director		None 1 M 2 □ F 20 Yrs.	Months Days	Hours Min.	March 2	Year 990 We	antry) Africa
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	e Ma r 28a notif	Dire	MD Prince Georges Upper Mar 10e. Street and Number					1 Yes 2 No
	th that the	ral		10f. Zip Code	,		10g. Citizen of What Co	ountry?
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(0	er de	by F	1 LA Never Married 2 Married 1 1 Vec 2 A No 1	Was Decedent of Hisp If Yes, specify Cuban,		Rican, etc.)	14. Race - Ame Black, Whit	
ဗ္ဗ	safte ral", Exar	효	3 Widowed 4 Divorced If Yes, Give Year or Dates,	1 ☐ Yes 2 🖺 No	Specify:		Specify: B	lack
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۱a	and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Haygiene. Health and Mental Haygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Merical Examiner must be notified at						City or Town, State, Zi	
ď.	and 2 lealth			Dunloring	Ct. Up	per Marl	boro, MD.	
or G	Page 1 annent of Page 1 annent of Page 1 annent of Page 1 annent between between page 1 annent between b		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cremation 3 ☐ Removal from State	osition (Name of matory or other place))	Date	20c. Location - City or	Town, State
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Europeral Service Licensee	2. Name and Address larshall s 308 _Suitla	Funeral and Rd.	Home of Suitlar	Maryland,	Inc. 46
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent- shock, or heart failure. List only one cause on each line.					Approximate
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DIVISION	recto	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, strubullding, etc. (Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Ru	ral Route Number,
5	ra af Disafed ir ded ir		January, etc. (Specify)			Only of Town	, otate)	
2007	Number browning and Autending Frigschan. The law requires that the beam certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, of the best of my knowledge, or the best of my knowledge,	tigation, in my opinion,	, death occurred a	t the time, date an	d place, and due to the	cause(s) and manner stated.
4	withir comp		29b. Signature and title of certifier	29c. License n	number	2	9d. Date signed (Monti	
			1 Stuaryou	250	21883		0/25/	10
0	1	Ī	30. Name and address of person who completed cause of death (Item 23a) (Type, F		1 300	20705	/	
	4		Hema P. Yadla, M.D. 3001 Hospital D 31. Date filed (Month, Day, Year) 32. Registrar's Signature	. Cheve:	rly, MD.	20/03		
	Stat Registra	٧ ١	JUN 2 9 2010 June 5. Jak					

DHMH 17 Rev 7/2009

			For State Registrar	State of Maryla		artment of F tificate of L			Reg. No. 2011	0 21615
	Physicia		Decedent's Name (First, Middle, La FRED ALLEN	st) BOWERS				2. Date of Dea Month June	Day Yes	3. Time of Death 10 : 05 PM
	Medic Examir		4a. Facility Name (if not institution, give	e street and number)			r Location of Death		4c. County of D	eath
	Funeral				rs. last birthday) Yrs.	FREDEF If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Augonth, D4	FREDER	Birthplace (State or Foreign
	Director		Usual Residence of Decedent	XX м 2 □ F 54	Yrs.	World's Days	Hours Will.	Aug gran, pag	Wareau 9 3 J	fry Vand
	aryland a-f sho fied at	Director	10a. State 10b. County WV Berk		City, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2
	th the Misa or 28 the noti	al Dir	10e. Street and Number 41 Gail Drive	<u> </u>		10f. Zip Code 2540	3		10g. Citizen of What U.S.A.	
(C)	er death wil or items 2	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🗶 🔊 o	l:	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto		14. Race - A Black, W	merican Indian, hite, etc.
-003	ours aft atural", cal Exar	eted k	3 Widowed XX Divorced 15. Decedent's	If Yes, Give Year or Dates.		Yes 2 XXNo			9,55	White
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	e Completed	(Specify only highest g	College (1-4 or 5+)	(Give I	kind of work done of NOT use retired) ack drive	during most of work	sing	16b. Kind of Busine	
yland	ld be filed Mental Hy iarked ott atic even	To Be	17. Father's Name (First, Middle, Last, Warren El	_	Bowers		18. Mother's Nam Betty	ne (First, Middle, Jane	Maiden Surname) Lawi	rence
Mar	d 2 shou alth and 1 27 is m or traum		19a. Informant's Name/Relationship (Tammy Jo Bowers	· · · · · · · · · · · · · · · · · · ·			and Number or Rur e, Martir		r, City or Town, State, WV 25403	Zip Code)
Baltimore,	Page 1 and ment of Heatant: If item tant: If item iury or othe		20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Dother (Spec	Removal from State	b. Place of Dispo cemetery, cren lagerstow	sition (Name of natory or other place on Cremat	ce) i	Date /2010	20c. Location - City Hagerston	
Balt	permit Depart Import any inj once,		21. Signature of Funeral Service Lice						ome, Inc.	25411_1855
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the done cause on each line.	leath. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
Ö	Medical		Immediate Cause (Final disease or condition resulting in death)	Don't de la company	quence of):	٥٠٠١٠٥	<u>~</u>		1	
	Examiner	Jer	Sequentially list conditions,	b. Due to (okas a cons	sequence of):	NEWA	obndo	come	tomor	
	ecuted and -transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Of Q	bdom:	en an	a ch	tre		
260	cate be executed physician and s the burial-transit	edical I		■ d						
Box 687	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. within 24 hours after death. or the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as to complete filled in by the funeral director, page 2.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of Month	delivery Day Year
P.O.	s that th gned by be detac	by	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause gi	ven in Part I.			e to the cause of death?
ords,	require been si should b	Completed						24a. Was	an 24b. Were	Probably 4 Unknown
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Vital	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ER/Outpatier	I ou	lace of Death (Chec er: 4 \sum Nursing H		dence 6 Other (S)	pecify)
n of	iding Ph th. : After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	28a. Date of injury (Month, Day, Year	28b. Time of	28c. İnjur worl	y at		ow injury occurred	
Division of Vital Records,	al or Atten s after dea i Director: d in by the	Certificate:	3 Suicide 6 Could not 4 Homicide determine	be 290 Place of Injuny A	at home, farm, streecify)			28f. Location (S City or Tow		Rural Route Number,
	Hospite 24 hours Funera leted fille	Medical	(Check 2 Medical Example (Check 2 Medical Example)	ysician: To the best of my kr niner: On the basis of examina rse Practioner: To the best o	ation and/or inves	tigation, in my opini	on, death occurred a	at the time, date a	and place, and due to t	he cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	Hee No	~~	29c. Licens			29d. Date signed (Mo	
-			30. Name and address of person who		Item 23a) (Type, F		Freder	•	0 2170	1
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	BORRES	TI EGET	icic III	· · · · · · · · · · · · · · · · · · ·	
> DHN	MH 17 Rev 7/2		1 (J. J. J. J.	CHILL MARKET	John M	7			<u> </u>	
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				aryland / Depa			Mental Hygie	ene	
			T = State RegistrarAmend#19b, 6/24/10,FC 1. Decedent's Name (First, Middle, Last)	HD, LE Cer	milicate of L	<i>Death</i>	Reg 2. Date of Death	No. 201	3 Tone to Bath
	Physicia Medic		Betty N. Connelly				June 22,	Day Year	0610 M
	Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or		ı	4c. County of Dea	th
	Funoral		Vindobona Nursing Home 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Braddoc	k Height If Under 24 Hrs.		Frederi	
	Funeral Director		216-22-1492 Usual Residence of Decedent	83 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye May 29, 1	927 Mary	rthplace (State or Foreign ountry) Tand
	land f show	후	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary 28a-1 otifie	Director	Maryland Frederick	Braddock	Heights				1 ☐ Yes 🏋 No
	n with the ns 23a or nust be r	Funeral D	10e. Street and Number 6012 Jefferson Boulevard		10f. Zip Code 217	714	10g	. Citizen of What Co USA	ountry?
21215-0036	ould be filed within 72 hours after death with the Maryland id Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates,	No I	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2🏋 No	n, Mexican, Puerto	pecify Yes or No- page Rican, etc.)	14. Race - Ame Black, Whit Specify:	
15-0	"2 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done di	ition uring most of wor	kina 16	b. Kind of Business	Industry
12	ithin 7 ene. r than	l E	Elementary/Seconday (0-12) College (1-4 or 5-	life. Do	O NOT use retired) emaker	anning mode on won	9	Own hor	ne
Maryland 2	e filed w Ital Hygi ed other event, t	To Be	17. Father's Name (First, Middle, Last) Norman Franklin				ne (First, Middle, Maid	den Surname)	
<u> </u>	should be fil and Mental 7 is marked o raumatic eve	-	19a. Informant's Name/Relationship (Type, Print)				Isabelle		
	2 shuth and the and the street is trau		Kathleen Connelly Daughter	19b. Mailin	ng Address <i>(Street al</i>) Peach O r	nd Number or Rui chard La	ral Route Number, Cit Brun ane , Bruns	y or Town, State, Zi SWICK WOCK Man	p Code) ~vland
Baltimore,			20a. Method of Disposition	20b Place of Dispo		- I		c. Location - City or	
<u>ĭ</u>	. Page tπent o tant: If jury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Darnestow	n Church	6-24-	-2010 Da	rnestown,	Maryland
Bal	permit. Page Department of Important: If any injury or		21. Sign ture of Funeral Service bicensee	22	Name and Address	-	tauffer Fu ike, Frede		
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death. Do not ente	er the mode of dying	, such as cardiac			Approximate
ar value	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	umoni	a				Onset and Death
	Examiner	_	Ecque itially list conditions,	consequence of: cles Mull consequence of: al Fibri	clw				YEALS
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7. O	es that t signed by I be deta	ē	Part II. Other significant conditions contributing to death but	t not resulting in the ur	nderlying cause give	en in Part I.			the cause of death?
oraș	/ requir	letec					24a. Was an		topsy findings available
VITAI Records,	The law ate has bage 2	Completed					autopsy performed	prior to death?	completion of cause of
	cian: T ertifica ector, p		25. Was case referred to medical examiner?		26. Plac	ce of Death (Chec	-	[NO] L Tes	S Z INO
<u> </u>	Physic this c	유	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatier 27. Manner of Death 28a. Date of injury	nt 2 ER/Outpatient		∆ Nursing He	ome 5 Residence		ify)
	inding ath. r: After ie funei	cate	1 Natural 5 Pending (Month, Day, 2 Accident Investigation	Year) injury	28c. Injury : work? M 1 \square	at ′es 2 □ No	28d. Describe how in	njury occurred	
JIVISION OF	l or Atte after des Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	et, factory, office		28f. Location (Street City or Town, St		ral Route Number,
ב	Hospital 24 hours Funeral rted filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of example 1.	amination and/or investi-	igation, in my opinion	death occurred a	t the time date and pla	ace and due to the o	cause(s) and manner stated
	To the vithin to the comple		only one) 3 ertifying Nurse Practioner: To the be	est of my knowledge, de	eath occurred at the t	time, date and plac	ce, and due to the caus	se(s) and manner as	stated,
			1000		18862	43	6	/22/10	
	3		30 Name and address of person who completed cause of deal RAYERN BOLDRUM, MILE	th (Item 23a) (Type, Pr	rint) PA	EDE 40	E PUITE	#131-2	1702.
	State Registra	~	31. Date filed (Month, Pay Year) 4 2010 32. Redistrar	s Signature	barre		1	" "	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:50 ам Beryl Wilton Caspar 2010 20, June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** <u>Rockville Nursing Home</u> Rockville Montgomery 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1□M 2፟A F Months Days Hours Director 567-26-5408 85 April 19,1925 Ohio Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at Director 1XYes 2 No Washington, D.C D.C. None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or it may injury or other traumatic event, the Medical Examiner must be none. 5108 Cathedral Ave. N.W. U.S.A Funeral 20016 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 🔀 No White Specify: Specify: ≦ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ John W. Wilton Esther Burgenson 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9712 Montauk Avenue Bethesda, Md. 20817 19a. Informant's Name/Relationship (Type. Print) Bethesda, Md. Patricia Ann Caspar/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 24, 2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00215 DeVol Funeral Home Henry Washington, D.C. 20007 2222 Wisconsin Ave. N.W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stare Dementia Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-transit that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be exect thours after death. Physician and Frencial Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 Other (specify) P.O. ed by the a 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 TYes 2 □ No 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ouma D0061382 June 24, 2010

DHMH 17 Rev 1/2001

State

Registrar

14816 Physicians Lane #152, Rockville, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Mittal,

JUN 25 2010

Shama 31. Date filed (Month, Day, Year) Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 0 0

			For State Registrar	otate of Maryla		tificate of De			eg. No.	
	Dhyaiai		1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day Year	3. Time of Death
	Physici /Medic			1e				June :	25 2010	8:58 p. ^M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or Loc			4c. County of Deat	hester
a god			Mallard Bay C 5. Social Security Number 6. Sex		s. last birthday)	Cambrio	lge Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign untry)
	Funeral Director			M 2 x F 82			Hours Min.	(Month, Day, Aug. 21	, 1927 Ma	ryland
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
C_{ℓ}	Mary Ind	tor	MD Dorchest	ter		Cambri	dge			1 ∑XYes 2 ☐ No
3	a or 282	Funeral Director	10e. Street and Number 520 Glenburn Aver	nue	-	10f. Zip Code	1613	10	ng. Citizen of What CoUSA	untry?
Maryland 21215-0036 0/2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Midfiel Exwigner must be realthed at once.	Completed by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 1 No If Yes, Give Year or Dates:		Mas Decedent of Hispa fYes, specify Cuban, M I □Yes 2√√2 No S	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W.	
2-0	72 hc 'natu	etec	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	dent's Usual Occupatio kind of work done durii DO NOT use retired)	n ng most of worki	ng	16b. Kind of Business/	Industry
121	vithin sne. than "	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. l	nomemaker			own ho	me
7	filed v Hygie ther i	ပ္ပို	17. Father's Name (First, Middle, Last)				. Mother's Name	(First, Middle, N	Maiden Surname)	
an	ld be ental ked o	To Be	Herbert Lee Harp	per			Marguer	rite Fra	nces Phill	ips
ary	shoul and M s mar umat	-	19a. Informant's Name/Relationship (Typ	ne. Print)					, City or Town, State, 2	
ž	and 2 salth a 127 is er tra		Donna Blackwell	p.r.			Circle,			ury, MD21804
Baltimore,	Pages 1 annent of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		sition (Name of natory or other place) e Cemetery	6/30		20c. Location - City or Cambridge	
Balti	permit. Departr Imports any Inju		21. Signature/of Funeral Service License	e		2. Name and Address of Coust S	1110		eral Home : MD 21613	P.A.
	Tifficate be executed Medical physician and as the burial-transit	cal Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	eselisa Lites / Anem strol	Sipt Ele	Heart &	Hoch	Onset and Death
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	es tha igned be det	by P	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying cause given i	n Part I.		bacco use contribute to	
ord	w requir s been si should I		Adva	year a	Clerk	slee		1 🗆 46		robably 4 Unknown
I Rec	ding Physician; The law h. After this certificate has b funeral director, page 2 st	Completed						24a. Was a autops perform 1 □ Yes	sy prior to	utopsy findings available completion of cause of s 2 □ No
Vita	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	ospital:		Othor		h (Check only on		
ot	g Physi ter this oneral direction	<u>ان</u> 2	27. Manner of Death	1 ☐ Inpatient 2 [28a. Date of Injury (Month, Day, Year)	☐ ER/Outpatier 28b. Time o Injury	II 3 DUA	/		ence 6 Other (Spe ow injury occurred	cify)
Division of Vital Records,	r Attending er death. rector: Aftei by the funei	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Sulcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		M 1 □Yes	s 2 □No	28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
莅	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phys	sician: To the best of my k	nowledge, deat	h occurred at the time,	, date and place,	and due to the d	cause(s) and manner a	as stated.
	the Ho iin 24 the Fu	Medical	one)	ner: On the basis of exami and manner stated.	nation and/or ir					
	To t To t	Σ	29b. Signature and title of certifier	, M.	D	29c. License n	335°	7	29d. Date signed (Mon	(I), Day, Year)
	\		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,	3 Byen	Steer	1 Can	beidge	MD-2161
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	Me de			J	

DHMH 17 Rev 1/2001

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Eor AMEND#19a, b per FH State of Maryland / Department of Health and Mental Hygiene 2 | 6 | 9 State Registrar 6/28/2010 AACO HEALTH DEPT. CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 0741 M CLOUD 2010 ACK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Spa Creek Center If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Months Days Hours OK 448-07-2739 85 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location Director 1 Yes 2 No Anne Arundel Annapolis 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 805 Janice Dr. 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ White 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates. 43-46 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) USNA Professor of PE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Riley Cloud Gertrude Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21401 Charlotte Ann Cloud Annapolis, 805 Janice Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 6/21/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service ocenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final acide oncho disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2- No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident (Month, Day, Year) injury 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number,

or Attending Physician: The law requires that the death certificate be executed as the burial-transit and signed by the attending physician d be detached for use as the burial Division of Vital Records, P.O. Box 68760 been s has ours after death.

eral Director; After this certificate filled in by the funeral director, pag Hospital 24 hours

Funeral

Director

28a-f shov

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ms 23a or 28a-f shorms must be notified at

Examiner

Medical

other traumatic event, the

Department of Important: If it any injury or o ō Page 1

Ph sician/

Medical

Examiner

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"natural",

1 and 2 should be filed within 7? Health and Mental Hygiene. item 27 is marked other than

3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioners To the best of my Indexledge, death oppointed at the time, date and plane, and due to the o 29b. Signature and title of certification 29c. License number

2

Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HIGHWAY NA in 441 Lalt

State Registrar

Medical

32. Degistrar's Signature Year) JUN 2 4 2010

within 2

To the F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21620 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHAUNCEY COVINGTON 7:22 1 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Hospital Prince Georges Lanham If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) March 13, 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Davs Hours Min. Director 577-36-9237 82 1928 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 ☐ Yes 2 X No Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9313 Lanham Severn Rd. 20706 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 1946 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) JO. 1 Never Married 2 Married Completed by filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1946949 "natural", 3 ☑ Widowed 4 ☐ Divorced Black Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor AAA12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Preston Covington Vallie Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian R. Mitchell-Niece East Alton St. Durham, NC 27707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 7-3-2010 Brentwood, MD. 4 Donation 5 Other (Specify) Signature of Euneral Service Licensee Marshall S Funeral Home of Maryland Suitland, MD. 20746 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Chronic Obstru Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Due to for as a nonsectionne off and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an has autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 2 110 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending

Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate completed filled in by the funeral director, after death Director:

24 hours Medical To the within 2

Registrar

31. Date filed (Month, Day, Year JUN **2 9** 2010

Investigation

6 Could not be

Accident

29b. Signature and title of certifier

3 Suicide

29a. Certifier

Hewson 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good huc RRd.

28e. Place of Injury - At hor building, etc. (Specify)

At home, farm, street, factory, office

Descritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year,

City or Town, State

		1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H rtificate of L	ealth and I Death	Mental Hygi	e2e0	0 2	21621
Dhyo	oion	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Year	3. Time of Death
Physi /Mei	dical	Sadie Francis D					6		010	9:45 a M
Exam	niner	4a. Facility Name (If not institution, give	street and number)			Location of Death	1	4c. County		
		5735 Onley Road 5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	Girdle		8. Date of Birth	Worce		ace (State or Foreign
Funera Directo	_		M 20XF 78	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1 - 29 -	Year) 1932	VA	try)
yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits
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17215-0036 within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow the Medical Examinations to relified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify	Blac	ck
21215-0036 sol within 72 hours aft giene. er then "natural", or t. It a Medical Exercit	ted	15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation	1	16b. Kind of B	usiness/Ind	lustry
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Mal d 2 st th an th an traur		1 .	pe, Print)		ng Address (Street a					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 ehow any injury or other traumatic event, the Medical Examination and indicated.	-	Diana Douglas 20a. Method of Disposition	20b. P	lace of Dispo	Onley I		Date 2	ee ML 20c. Location -	City or To	wn, State
Baltimore, Dermit Pages 1 ar Department of Hea mportant: If Itam any injury or other		1X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	temoval from State	•	matory or other place Ga	الممد	6-2010_1	Uobror	MI	
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. Box 68760, death certificate be executed e attending physicien and id for use as the burial-transit	an/N	230. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy				te of delive	
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VISION OF VITA Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe ho			,
ath.	atio	1 Natural 5 Pending 2 Accident investigation	(Monan, Day rear)	mijury		Yes 2 □No				
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DIVISION Of VITAI RA To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: Affer this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	and due to the ca	tuse(s) and mate and place,	anner as st and due to	ated. the cause(s)
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V		31. Date filed (Month, Day, Year)	DECONOLS 32. Registrar's Signa		lisbury	m0 2	1801			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink For State of Maryland / Department of Health and Mental Hygiene 21622 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20/0 1821 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL Alcim ico SAUS 64 MY Security Number Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State of Foreign **Funeral** (Month, Day 1 □ M 2 🕱 F Months Days Hours 78 MARY Director 28-448-Usual Residence of Decedent show 10a. State : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 10d. Inside City Limits UANTICO MARULAND 1 ☐ Yes 2 No :com:co 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5967 UANI 21856 7 Co Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify: Black 3 🗌 Widowed 4 🗎 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) NONE Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည :1+ on KIDER KOXIE TRICE permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd WIER HANDOVER 21076 Florey imb ERLY U JON 6000 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Deurial 2 Cremation 3 Removal from State pring hil 4 ☐ Donation 5 ☐ Other (Specify) -29-10 ma EDWN Signature of Funeral Service Vicen 21. Name and Address of Facility WAR (-UN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death COR Pulmonale Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Bronchiolitis Obliterans Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury the attending physician and ned for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Etta 10 Hazel Dunn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-RMC Allegany Cumberland Birthplau Country) CA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Jan 9, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □ ¥ Months Days Hours Min. 1952 565-88-7702 Director 58 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at MD Allegany Cumberland Director 1 □Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 13709 Moores Hollow Road S.E. 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify 9 Specify: 3 Widowed 4 Divorced white Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If Item 27 Is marked other the any injury or other traumatic event, It all pines. Alpha Plumbing office manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Gross Alpharetta (Coop) Gross မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Gross brother Cumberland MD 21502 549 Green Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Gremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 7/5/2010 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Scarpelli Funeral Home, PA 21. Sign ture of Funeral Service 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Inter the dispuse or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PCTIFOHIH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CIN Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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High Luft C 23e. Did tobacco use contribute to the cause of death? 2 1 Tyes 2 Tho 3 Probably 4 Unknown Be Completed Gaulblodder Lymphoma 24a. Was en 24b. Were autopsy findings available prior to completion of cause of autopsy Certification: To

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Penneral Director: After this certificate has been signed by the attending physician and leiely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, To the Hosp within 24 hou To the Fune completely fi

					performed? 1 ☐ Yes 2 ☐ No	death? 1 □ Yes 2 □ No
25. Was case refer examiner?	red to medical			26. Place of Dea	th (Check only one)	
1 ☐ Yes 2 ☐	No	Hospital: 1 ☐ Impatient 2 ☐	ER/Outpatient 3 ☐ D	OA Other: 4 I Nursing H	ome 5 ☐ Residence 6 ☐	Other (Specify)
27. Manner of Deatl 1 ☐ Natural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ∐Yes 2 ∏No	28d. Describe how injury of	ccurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factor	y, office	28f. Location (Street and N City or Town, State)	umber or Rural Route Number,
29a. Certifier	1 ☐ Certifying Ph	ysician: To the best of my kno	wledge, death occurred	d at the time, date and place	e, and due to the cause(s) an	d manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier unwellen)

29c. License number 00053158

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STASKO 924 SETON DRIVE CUMBERLANDIMD 21502 M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

(Check only

DHMH 17 Rev 1/2001

			_ For	Plea				Black II d / Depa					ental Hy	giene	е		0.1	c 2 l.
		-	State Registrar					Cei	rtificat	e of D	eath				201	U		624
	Physicia Medic	al		rothy	Viola	Erhan	it						June 21	, 20	îb	Year		:32 A M
	Examir		4a. Facility Name (if Souther	not institution, n Marylai						Town, or L Clinto		f Death		40	c. County Princ		rge's	
	Funeral Director		5. Social Security No. 578 30 828		6. Sex 1 ☐ M 2			ast birthday) 31 Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	3. Date of Bir Month, Da July 26	th ly, Year)	28	9. Birth	place (State try) Land	te or Foreign
			Usual Residence of 10a. State					y, Town or Lo	cation							1	0d. Inside	e City Limits
	e Maryla - 28a-f s notified)irect	Maryland 10e. Street and Nun		George	s		Suitla	_	p Code				- 12				Yes 2 XXNo
	s 23a or	eral [lies Roa	i				101. 21	2074	6				ted St		itry?	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Marri 3 WWidowed		ied 1 [as Decedent med Forces? Yes 2 Yes, Give		'	f Yes, spe	dent of His cify Cuban 2 🙀 No	, Mexican,	jin? (Speci , Puerto Ri	fy Yes or No- can, etc.)			k, White,	ean Indian, etc. ite	1
21215-0036	72 hour n "natu ledical	nplet		cify only highe	1	pleted)		16a. Deced	dent's Usu kind of wo	rk done du	tion uring most	of working	1	16b.	Kind of Bu	ısiness In	dustry	
212	within giene.	Co	Elementary/Seco	onday (0-12)	Co	llege (1-4 or	5+)		maker					Ow	п Ноле	2		
and	ntal Hy ed oth event	To Be	17. Father's Name (ast)						18. Mothe	er's Name (Augus	First, Middle,	Maider dtke	Surname)		
Maryland	nould b nd Me s mark umatic		James (_	ip (Type, Prin	nt)		19b. Mailir	ng Addres	s (Street ar	nd Number		Route Numbe		r Town, S	tate, Zip (Code)	
	and 2 sh lealth a lean 27 is her trai			Erhardt	(SON)		- Tan	<u> </u>		ies Ro	ad, Su			2074		0: 7		
more	age 1 a ent of h nt: If ite ry or ot		20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation	Cremation	3 Remov	al from State	, C6	lace of Dispo emetery, cren e Cremat	natory or o	me of other place,		Da Jumo 22	te 2, 2010				own, State	
Baltimore,	permit. F Departm Importal any injur		21. Signature of Fur		icensee		21522	22	2. Name ar		of Facility	Lee Fu	meral H				d Alex	xandria
Ē	20200	\vdash	23a. Part 1. Enter the	ne disease, or t failure. List o	complication	is that cause	d the death			oad, Code of dying,				rest,		T	Approxir	nate
made	Physician/ Medical		Immediate Cause (disease or condition resulting in death)	Final	a	VEN	TRI	W/AR	- A	RRI	Hh	mu	Á		_		Onset ar	
كم عدوات	Examiner			aditiona		Due to (or as	e Ch	nence of):	te	(m	3A1+	Anic	٩		_			
	ed	Examiner	Sequentially list confidence in any, leading to improve cause. Enter Under Cause (Disease or that is in the cause or the cause of the c	mediate lying linjury	5	Due to (or as	a consequ	ence of):	CA	-(,	11-8							
	e executivian and urial-tra	al Exa	that initiated events resulting in death) l	,	c. <u> </u>	Due to (or as	a consequ	ence of):						•				
760	cate be physics the bi	ledica		10	d											1		
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Law Law Law and Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 9 9 ☐ Unknown	nonths?	1 4	res, outcome Live Birth Pregnant a Unknown	2 - Fetal	Ideath 3	Ectopic Other (s	pregnancy pecify)					23d. Dat Moi	e of deliv	ery Day	Year
, P.O.	requires that the de been signed by the should be detached	by Pi	Part II. Other signif	icant conditio	ns contributi	ng to death b	out not resu	ulting in the u	ınderlying	cause give	n in Part I.		23e. Did t					of death?
ords	v require s been s s should	oleted											24a. Was	an	24b. V	Vere auto	psy finding	gs available of cause of
Rec	The law cate has page 2:	Com											auto perfo 1 Yes	ormed? 2 X N		leath?		
ital	ician: The certificate rector, pag	m	25. Was case referred examiner?	d to medical	Hospita	l:	~			Other		h (Check o						
of V	iding Physician: T th. After this certifica funeral director, p	te: To	27. Manner of Death			1 ∐ Inpat a. Date of inju (Month, Da	iry	ER/Outpatier 28b. Time of injury	-	OA J 28c. Injury a work?	4 ⊔ Nui		e 5 🗌 Resi d. Describe l)	
Division of Vital Records,	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu	Medical Certificate:	2 Accident 3 Suicide 4 Homicide	Investig 6 Could redetermine	ation not be	. Place of Inj	ury - At hor	me, farm, stre	M eet, factor	1 🗆 Y	es 2□	_	If. Location (S			r or Rural	Route Nu	ımber,
۵	ospital o hours af neral Di d filled in	lical C		Certifying	Physician: T	o the best of	my knowle	edge, death o	occured at	the time, o	date and p	place, and	due to the ca	use(s) a	nd manne	er as state	id.	
	the Hothin 24 the Fu	Mec	(Check 2 only one) 3	☐ Medical E ☐ Certifying	Nurse Pract	the basis of e tioner: To the	best of my	knowledge,	death occu	my opinion arred at the c. License r	time, date	and place,	and due to th	e cause	e, and due (s) and ma ate signed	nner as st	ated.	manner stateu
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	BRE		30. Name and addre	ess of person v	vho complete	ed cause of c	death (Item	23a) (Type, F	Print)	(1)	Lind	TI	m	21	72	7		
	Stat	е	31. Date filed (Mont)	N 2 S	onto I		ar's Signat	ure Tree	201	7, /	MI	IOI	1117	رين_				
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			State of Maryland / Dep			∕lental Hygi	ene	01605
			1109.01.01	rtificate of D	eath		eg. No2 0 1 0	21625
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Douglas Page Elmore			2. Date of Death Month	26 18	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death	,	4c. County of Deat	
	/		PENNSULA REGIONAL MEDICAL CONFY	If I and a 1 Vanu	3AU3644	1.5. (5)	Hicom	
	Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthday) 228-48-1296 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, 05/31/1	Year) 9. Bin 939 Vir	hplace (State or Foreign untry) 'Ginia
			Usual Residence of Decedent					
	ryland -f sho ied at	Funeral Director	10a. State 10b. County 10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28a notif	Dire	Maryland Wicomico Salisbur	10f. Zip Code		1	Og. Citizen of What Co	
	with th	əral	4200 Union Church Rd	218	801		USA	
	items	Fun	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spen	ecify Yes or No-	14. Race - Ame	
36	filed within 72 hours after death with the Maryland tral Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 Never Married 2 KM Married 1 Yes 2 KM No If Yes, Give	1 ☐ Yes 2 X No		Thous, orony	Black, White Specify: 7,	hite
8	nours latura ical E	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupa	ation	3 1	16b. Kind of Business	
215	in 72 h e. nan "n Medi	duc	(Specify only highest grade completed) (Give	e kind of work done di DO NOT use retired)	uring most of work	ing		,,
2	withi ygiene her th	Be Co		islator			governmen	t
and	be filed ental Hy rked oth ic event	To B	17. Father's Name (First, Middle, Last) Charles Truhart Elmore Sr.			e (First, Middle, M et Johns		
JZ.	ould bud Me		<u> </u>	ing Address (Street a			City or Town, State, Zip	Code)
ĭ	d2sh althau n27is ertrau		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				sbury, MD	
Baltimore, Maryland 21215-0036	e 1 an t of He If iten or oth	i	20a. Method of Disposition 1 🔀 Burial 2 🔲 Cremation 3 🗆 Removal from State 20b. Place of Disposerery, cre	osition (Name of ematory or other place	e) [20c. Location - City or	
ţ	t. Pag rtment rtant: rjury o		4 Denation 5 Other (Specify) Parsons C			/2010	Salisbury	
Bal	permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic evenonce.	i i	21 Shapehard of Funer al Service List see	HOTTOWAY 501 Snow	Funeral : Hill Rd.	Home Pro: , Salisb	fessional . ury, MD 21	Association 804
				ter the mode of dying				Approximate Interval Between
	Physician/	8 V	Immediate Cause (Final disease or condition	prostate	cance	r		Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):					
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	cate be executed physician and s the burial-transit	Examiner	that initiated events C.					
_	oe exe ician a burial-	dical E	resulting in death) Last Due to (or as a consequence of):					
760	icate t phys s the l	ledic	d					
89	eath certifica attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3	☐ Ectopic pregnancy	v		23d. Date of de	livery
Box 687	death	Physician/Me		Other (specify)	,		Month	Day Year
P.O.	ires that the dea signed by the a ld be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
S, I	uires ti n sign	ed by				1 □ Ye	s 2 7 No 3 7 P	robably 4 🗆 Unknown
örö	w require ts been si 2 should l	Completed				24a. Was an		topsy findings available completion of cause of
Rec	sician: The law of certificate has be lirector, page 2 s	Com				perform 1 Yes 2	ned? death?	s 2 □ No
tal	ician: sertific ector,	Be	25. Was case referred to medical examiner?	/ Otho	ace of Death (Chec	k only one)		
Ž	Physical direction	: To	1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manper of Death 28a, Date of injury 28b. Time of	ent 3 L DOA	4 ☐ Nursing Ho	ome 5 Reside	nce 6 Other (Spec	ify)
o uc	nding ath. :: After e fune	icate	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work?		204. Describe no	r injury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	cal (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time.	date and place, ar	nd due to the caus	e(s) and manner as sta	ated.
	n 24 h	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invest	stigation in my oninio	n death occurred a	t the time date and	place and due to the	cause(s) and manner stated.
	Withi To th	_	29b. Signature and title of certifier	29c. License	number	29	d. Date signed (Monti	
	7		* + # (sk)	HOO.	27368		6/26/1	0
	Tal		only one) 3-15 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, 100 C C C C C C C C C C C C C C C C C C	Print) Sali	shum n	11 2 (8	70/	
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1				
	Registra		JUN 28 2010 Kenua S.	best				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Fetterman James 8:30 AM June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Regional Hospital .dure 8. Date of Birth 1912 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 ★ M 2 □ F Hours Months Jully 15, 2010 Pennsylvania 97 Director 025-16-8170 Yrs. Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f must be notified 1 ☐ Yes 2 🛣 No Florida Palm Beach North Palm Beach 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 Funeral 23a 336 Golfview Rd. #419 33408 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Xyes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ ö 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: 3 K Widowed 4 Divorced Completed White Year or Dates. of Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Navy Chief Petty Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Miller Anna Earl Fetterman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1529 N. Bowling Green Drive, Cherry Hill, NJ 08003 John Hammond-nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State per nit. Page 1 a Der artment of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Washington Crm. June 23, 2010 Laurel, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Fleck Funeral Home, INC.
7601 Sandy Spring Rd. Laurel, Maryland 20707 MYG M0125 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Physician/ Respiratory disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the attending physician and hed for use as the bunal-transit neumonia Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 1 L Yes 2 L g L Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Urosepsis Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No 2 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 XNo Other: 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at ie Hospital or Attending P n 24 hours after death. ie Funeral Director: After t 28d. Describe how injury occurred After t Natural 5 Pending 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D60936 June 16, 2010 Dusen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdul M. Tak, MD Regional 31. Date filed (Month, Day, Year) State JUN 2 4 2010 Registrar

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** M ASS 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 100 Spring Place Way Annapolis 9. Birthplace (State or Foreign Country) Louisiana If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year 2/6/1946 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Year Days Hours 587-54-2143 1 M 2 F 64 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f shovevent, the Medical Experience, ust be notified at Annapolis Anne Arundel Maryland 1 ☐ Yes 2 🛣 No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 21401 100 Spring Place Way Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: þ 3 Widowed 4 Divorced Completed 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy injury or other traumatic event, I ame any injury or other traumatic event, I amone. Library System Library Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Weathersby Merle Francis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles Steadman - Husband 100 Spring Place Way, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakewood Mem. Park 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/28/2010 Jackson, MS 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses Myelin Tillolot 147 Duke of Gloucster St, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 10015 CUNCIE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p for use as t If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performe certificate 2 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: / 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide i 24 hours a e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical mpletely: (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signaty title of certifie and address of person who completed cause of death (Item 23a) (Type, Print) 06 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 12:30 AM rearni 2010 Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** ashingtor . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace State or Foreign **Funeral** 90 Yrs. 1 M 2 F Months Hours Min **Director** 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director other traumatic event, the Medical Examiner must be notified 1 🗆 Yes 2 🕅 No artinsburo ò 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 2 2540 rive "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 9412 Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygleine. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) <u>owner</u> è iverside operater Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) eulah , Martinsburg Fearnou 499 Diva 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 7-7-2010 Berkeley Springs 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyrnaral Service Licensee 22. Notine and Address of Facility Hunter-Anderson Funeral Home Green Street, Berkelei 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Shuste Inchem disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 9 Unknown 2 🗌 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 🗌 Yes 2 🖺 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 1110 1 Tyes မ 1 Lapatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔁 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D18019 JULY 5, 2010 actus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21740 MAGERIZOWON DATTA MO 340 MILL ST

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Dr

32. Adgistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BARBARA A. FLOWERS 06/25/2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🕮 F Hours Min. (Month, Day, Yea. Country) MTSSOURT Director 498-44-3217 70 Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1X Yes 2 ☐ No MD PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12525 TOVE ROAD 20735 USA items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Examiner Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 9 1 Never Married 2 Married Completed by 2 X No ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give Specify:BLACK 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.

7 is marked other than traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) BEAUTICIAN PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 1 and 2 should be in Health and Mentalitem 27 is marked other traumatic e DEWITT DAWSON JANNETT MCMILLIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other GAIL FLOWERS/DAUGHTER 12525 TOVE ROAD CLINTON, MD 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) RESURRECTION CEMETERY 07/01/2010 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition PU mana Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death Dav Year 1 Yes 2 9 Unknown the Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ᅙ 1 🗌 Yes 2 No Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury s after death.

I Director: After to in by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi

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Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

JUN 2 9 2010

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 21630 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gertrude P. Gibson 2010 34 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 102 Skipjack Circle Berlin Worcester Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Hours Min (Month, Day, Year) 17/1933 Director 213-28-7955 Usual Residence of Decedent fshow Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Worcester Berlin 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Skipjack Circle 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Herlth Catherine Haller permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel T. Gibson / husband 102 Skipjack Circle, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Durial 2 Cremation 3 Removal from State 6/25/2010 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Cre: 21. Signatur f Funeral Service I 22. Name and Address of Facility Burbage Funeral Home 108 William Berlin, St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final D10 m 40 Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes No
9 Unknown Month Year 4 Pregnant a Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one. examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any hintor or other traumatic event. the Medical Examiner must be notified at			20a. Method of Dispos 1 🔲 Burial 2 🔀		3 Removal from	m State	cem	e of Dispos etery, crem	atory or oth	ner place			ate			City or Tov	
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Division of Vital Records, lal or Attending Physician: The law requires is after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be	.	Certificate:		6 Could r	ot be 28e. Plac	e of Injury	/ - At home	e, farm, stre							d Numbe	r or Rural i	Route Number,
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Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2.8		Medical	(Check 2 -	Medical Ex		asis of exa	mination a	nd/or investi	igation, in m	y opinio	n, death oc	curred at t	he time, date a	nd place	, and due	to the cau	se(s) and manner stated.
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		İ	30. Name and address	of person w	ho completed car	use of dea	ath (Item 23	3a) (Type, P	rint)								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21632 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June ^{Day} 2010 Joseph Gancie 22, 8:15 p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 13100 Camellia Drive Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) March 2, Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Country) New York 1**X**□ M 2 □ F Months Director 068-12-4134 87 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at Director 1 🗌 Yes 2 🏝 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 13100 Camellia Drive 20906 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 X Married IX Yes 2 If Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: res, Give Year or Dates. 1942-83 Specify. "natural", 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Communications Corporate Executive Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Ganci Rosalie Sottile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3059 Porter Street, NW, Washington, DC 20008 Patrice R. Gancie/Daughter other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date Ь 1 🗌 Burial 2 🗷 Crema June 23 2010 © □ Other (Specify) Alexandria, VA injury (4 Donation 22 Name and Address of Facility Funeral Home Inc. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature ice License neral Se any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Congestive Heart Failure vrs Medical Due to (or as a consequence of) Examiner Coronary Artery Disease vrs encifibrion tell vilettriaus if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Vear Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes, Hypertension, Cardiomyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home SXX Residence 6 Other (Specify) 2 🕱 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No Natural 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 23, 2010

State

Registrar

10301 Georgia Avenue, #209, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anuradha Arun, MD

25

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 19a per FH State of Maryland / Department of Health and Mental Hygiene 2/2010 AACO HEALTH DEPT. CMH Cartificate of Death 21633 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Ye ar Allen etty TIJMO 201C /Medical . Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UTURECARE esa Peake RNOL RUNDER If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Pay, Year 8/1/1930 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Min 79 212-05-5767 Director Mary Land Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Inc. Modical Examinar must be reaffined once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland | Anne Arundel Arno1d 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 186 Campus Green Drive 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 □Yes 2 □ No Specify: ģ Specify: White 3 Widowed 4 Divorced Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin C. Galloway, Sr. Ethel M. Homberg ဥ 19a Informants Name/Relationship (Type Print) Dorald B. Galloway SR. Brother John F. Galloway/ Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 146 Calhoun St., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State Hillcrest Cemetery 4 Donation 5 Other (Specify) 6/25/10 Annapolis, MD 21. Signature of Formal Service Ecensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MPHOMA disease or condition resulting in death) MONTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent premant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performe 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1∐Yes 2⊠No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 TYes 2 No ☐Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director:
completely filled in by the

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

nd address of person who completed

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per inf g905 7-27-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 2010 7:10 PMM Cora E. Grant Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Hospice Social Security Number 28 213 - 98 - 9099 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F West Virginia Months Days Hours Min 04/25/1919 Director 91 9099 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò Funeral with 23a 1900 Grove Manor Drive - Apt. 405 21221 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔼 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes X No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew J. Hawkins Lillie Belle Tolley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Kennedy (daughter) 331 Tosch Street - New Smyrna Beach, Florida 32168 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gdns: 07/10/2010 Bel Air, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 6 11750 Belair Road - Kingsville, Maryland 21087 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on jach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ eno car cinomo N:00KA disease or condition Medical resulting in death) e to (or as a consequence of) **Examiner** Sequentially list conditions, One to (or as a nonsequence of) if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death the detached 9 Unknown P.O. | þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≙ Records, 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner' Hospital Other: 1 Tes 2 No ဂ္ဂ 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation М filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioney: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ure and title of 29b. Sigr License number 29d. Date signed (Month. Dav. Year) and address of person who completed cause of ceath (Item 23a) (Type, Print) 30. Name TIMONIUM, MD)21093 ERNESTINE WRIGHT, 2300 DULANEY VALLEY ROAD M.D.31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

2010

GRANT

CORA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2°Y June Physician/ 2010 10:30PM John Edwin Hannon Medical 2234 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Hospital 9. Birthplace (State or Foreign Country) Wash. D.C 7. Age (In yrs. last birthday) 75 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** March 4, Year 1935 Min. Months Days Hours 1 🔀 M 2 🗆 F 577-46-5921 2010 **Director** Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland Director 1 ☐ Yes 2 🛂No Elkridge MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA ANG 21075 6155 Shadywood Rd. Unit 204 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

XX Yes 2 \(\text{D} \) No \(\text{1958-} Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Mariana once. 1 Never Married 2 Married Completed by ☐ Yes 2 🖾 No Specify Specify: White 3 Widowed 4 Divorced 1960 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Electrician Be ANY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Marion Rowzee Coleman Hannon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6155 Shadywood Rd. Unit 204, Elkridge, MD 21075 19a. Informant's Name/Relationship (Type, Print) Janet Hannon / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JOHN 1 🔲 Burial 2 🗆 Cremation 3🌠 Removal from State June 28, 2010 Herndon, VA Chestnut Grove Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry II. Witzke's Family FH, Inc. M01411 Signature Fune of S rvice Licensee 4112 Old Columbia Pike, Ellicott City, MD 21043 190 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final acute pirat Pnysician/ Ihour disease or condition **≰** Medical resulting in death) Due to (or as a consequence f): Zweeks Examiner neumonia Sequentially list conditions, Due o (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Exami The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 🗀 Fetal death Ectopic pregnancy 3 Day in the past 12 months? Month Year Other (specify) Pregnant at time of death ed by the a detached t 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, cate has been siç ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Yes this certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 2 X No 1 Inpatient 2 KER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury **Natural** 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the ! only one) 29b. Signature and title of confice 29d. Date signed (Month, Day, Year) 100 M 2010 21 JUNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, MD Jennifer George-Morcos MD Registrar's Signature State neur.

Registrar

10-04587 Veronica Lynn Hard	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ing-Perkins State of Maryland / Department of Health and Mental Hygiene 2 1 1	21636
	1- For State Certificate of Death Reg. No.	21030
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year June 17, 2010	3. Time of Death 0547 hrs
97	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 12102 Main Street Libertytown 4c. County of Death Frederick	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 In Months 1 In	
d sow any	7,	10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Number	у?
er death w , or items r must be Funer	11. Marital Status 1	
36 uin 72 hours afture. than "natural" dical Examine pleted by	15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Ind	
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica Be Comple	12 Horse Trainer Equestria 17. Father's Name (First, Middle, Last) Mahlon Simmons Connie Kuhn	<u>n</u>
MD 21; 3 2 should be the and Men a 27 is mar unmatic eve	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z Dean Perkins 12102 Main Street, Libertytown, MD 21762	,
Baltimore, permit Pages I and Department of Heal Important: If iten injury or other tra	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To crematory or other place) Stauffer Crematory 06/24/10 Frederick,	MD
Balti permit. Departin Importi injury o	22 Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD	21702
Physician Landing Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds	Approximate Interval Between Onset and Death
remarks.	Sequentially list conditions, b	
ted 1 Insit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	-
a tra	d. UNPENDED AMENDED	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial edical Certification: To Be Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	y Year
ords, P.O. B w requires that the d is been signed by the should be detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the 1 Yes 2 V No 3 Probab	
Records, The law require, ficate has been sig, page 2 should be	autopsy prior to condeath? 1 ✓ Yes 2 No 1 ✓ Yes	psy findings available impletion of cause of
Vital I ysician: his certifi director,	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Vother: S	Scene
on of vending Ph. sath. or: After tl	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Subject shot by police	
Division or spital or Attending bours after death. neral Director: After filled in by the fune. Certification:	Suicide 6 Could not be determined (Specify) Single Family Home 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural or Town, State) 12102 Main Street, Libertytown, MD	Route Number, City
To the Hos within 24 h To the Fun completely	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
A P E S E S	295. Signature and title of certifier 29c. License number 29d. Date signed (Month) 39d. Date signed (Month) 4 June 18, 2010	ı, Day, Year)
7	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	And the second s	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monthun 17 2010 6:15 P M SYDNEY ALEXIS HODGKINS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Country)
Maryland **Funeral** June 17, 2010 1 □ M 2 🖺 F Days Hours Director None Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Baltimore City Baltimore 10f. Zip Code 10g, Citizen of What Country? ō 23a Funeral with 508 South Hanover Street 21201 United States items ? be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ō á 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give White 1 ☐ Yes 2 X No Specify Specify: "natural", 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) None Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lucas Hodgkins Misty Sims permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Misty Hodgkins/Mother South Hanover St. Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 6/25/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M01463 22. Name and Address of Facility Simple Tribute Signature of Fungral Service Licensee 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the obsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fall re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) EXTREME PREMATURITY) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a Id be detached f 9 Unknown 1 ☐ Yes 2 △ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🗌 Yes 2 **X** No 1
☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify)

this certificate has ral director, page 2 funeral director, within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

Certificate:

Medical

Division of Vital Records, P.O. Box 68760

Maryland 21215-0036

Baltimore,

27. Manner of Death 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 4 Homicide determined

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [only one) 29b. Signature and title of certifier

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. M.D.

28a. Date of injury (Month, Day, Year)

29c. License number

28c. Injury at

work?

1 Tyes

2 🗌 No

29d. Date signed (Month, Day, Year)

01066987A (IN) NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MC

LT USN KATRINA VONGSY

31. Date filed (Month, Day, Year) JUN 25

State

Registrar

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William Edward Hastings 28,2010 0259 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomico Salisburg Rehabilitationa Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (In 71s. last bir Salsbyrg 8. Date of Birth (Month, Day, Year) April 2,1927 Birthplace (State or Foreign Country) If Under 1 Year (In rs. last birthday) **Funeral** Months Days Hours Min 1 XM 2□ F Maryland 83 218-20-9369 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County or items 23a or 28a-f show 1 X Yes 2 ☐ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examination in the perfect Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number USA 21804 333 Barclay Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1945 William Hastings Baltimore, Maryland 21215-0036 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ∐Yes 2 XNo Specify White 1946 Specify: ģ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Public Utility Dispatcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lavinia Blanche Marvel Clayton Jude Hastings ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 406 West Drive, Snow Hill, Maryland 21863 Sherry L. Foster/Friend 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Salisbury, Maryland 7/2/2010 Parsons Cemetery 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, 21. Signature of Funeral Service Lice MD 21802 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Erear disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed 1 ☐Yes 2 ☐No 2 🖪 No 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 LNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 4 Hours after death.
4 Hours after death.
5 Inneral Director: After tely filled in by the funera After t 1 AMatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar vic Ave.

	1	For State Registrar	State of Maryland / I		tificate of I		Re	eg. No.			
Physicia		1. Decedent's Name (First, Middle, Last)	IOAN MADIE HINNA	MT			Month	Day	Year		
/Medica	al –	4a. Facility Name (If not institution, give s	JOAN MARIE HINNA	TIAT	4h City Town or	Location of Death		-			
Examine	r	6115 CHICAMUXEN R			INDIAN H			CHAI	RLES		
Funeral Director		5. Social Security Number 6. Sex	M 2 TF 57	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month Dev.	Year)	9. Birth Cou 2 MINN	place (State or Foreign intry) NESOTA	
P .		Usual Residence of Decedent 10a. State 10b. County	10c, City, Toy	m or Lo	cation		2. Date of Death				
Aaryla Fethov	5										
the h	Director	10e. Street and Number			10f. Zip Code		1	-		ntry?	
h with	a	6115 CHICAMUXEN RO	AD		20640	· ·					
oris a	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 <mark>X</mark> No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Spe	lack, White cify: WH), etc. ITE	
72 hours	eted	15. Decedent's Educ (Specify only highest grade	ation 16a	(Give	dent's Usual Occup	during most of wor	king	16b. Kind of	Business/I	ndustry	
4 within 72 hours at jiene. Then "netural", or the Madical Exami	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired T AGENT			AIRLI	NES		
W 5, M -:	ပို့	12 17. Father's Name (First, Middle, Last)		IONI	I AGENT	18. Mother's Nar	ne (First, Middle,	Maiden Sum	ame)		
E da la p	To B	JAMES HARDEN									
Mar nd 2 sho lith and 27 is m r traum		19a. Informant's Name/Relationship (Type WILLIAM G. HINNANT	· ·	ь. Маізіг 115	ng Address (Street CHI CAMUX	and Number or Ru EN RD, Il	NDIAN HEA	AD, MD	2064	0	
0 0		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	anmat.		sition (Name of matory or other place CTION CEM	ETERY JU	4.0				
baltimo		21. Signature of Funeral Service License		22	2. Name and Addre	ss of Facility DE	MAINE FU	NERAL	HOME	0.000	
Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death Do	not ent						Approximate Interval Between	
Examiner	-	Sequentially list conditions, if any, leading to in modulate		ws.							
uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
68 / 60, cate be executed physicien and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a consequence	e of):							
68 tifficati	Vedi	15 5511115							-		
Hecords, P.O. BOX 6 The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	it 12 gonths? 4 Pregnant at time of death 5 Other (specify)								
dS, P.O.	ρ	Y									
VITAI HECORDS, sicien: The law requires t certificate has been signe rector, page 2 should be	Completed						autop	med?	prior to death?	completion of cause of	
	BeC	25. Was case referred to medical examiner?					ath (Check only o	ne			
- × × v	ှ	Yes 2□No	lospital: 1 ☐ In patient 2 ☐ ER/C 28a. Date of Injury 28b	outpatie . Time c	nt 3 DOA					cify)	
DIVISION OF or Attending Phy after death. Director: After this I in by the funeral d	ation:	27. Manner of Death 1XXNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Work? 1 □ Yes 2 □ No							
DIVISIC tal or Attenc s after death al Director: ed in by the	Certification:	4 Homicide determined	building, etc. (Specify) City or Town, State)								
DIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								e to the cause(s)	
Toti Toti com	W	29b. Signature and title of certifier Yelling	r. Tægani		29c. Licen	se number 50883		June	26	Z 6 0	
20		30. Name and address of person who co	empleted cause of death (Item 23a	OIN	Print) LOOKOUT	RD, LEO	NARDTOWN	, MARY	LAND	20650	
Sta Registra	_		32. Registrar's Signature								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ . MONE *P* 20 **Y DEBORAH** HOLLIDAY 1:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERY SUBURBAN HOSPITAL BETHESDA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 K F Days Hours. AUG 28, 1955 WASHINGTON, DC Director 577-76-9630 54 Usual Residence of Decedent 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD PRINCE GEORGE'S ACCOKEEK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2403 GREEN GINGER CIRCLE 20607 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical on we 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CONTRACTOR OFFICER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LILLIAN MARROW CHARLES H. WARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> WILLIAM HÖLLIDAY-HUSBAND</u> GREEN GINGER CIRCLE ACCOKEEK, MARYLAND 20607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY 7/1/2010 BRENTWOOD, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Europal Service 1. 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ENECPHALOPATHY Medical **Examiner** ASPIRATION PNEUMONIA Sequentially list conditions, If any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Disk to (or as a consequence) of Exami RESPIRATORY FAILURE that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician a detached for use as the burial-Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box the Hospital or Attending Physician: The law requires that the death in the past 12 months? Day Year 1 ☐ Yes 2 🛣 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2X No 1 Yes Be **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hnpatient 2 ER/Outpatient 3 DOA Certificate; To After this (27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Director: . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 229256

State Registrar

7

Olytho

4343 MONTGOMERY AVENUE # 102 BETHESDA, MARYLAND 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

QUIROS M.D.

32. Registra s Signa re

<u>an</u>tonio

31. Date filed (Month, Day, Year)
JUN 2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16^{Day} 2010 JUNE Physician/ TABITHA HUMES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Mitchellville 11409 Waeche Dr. Birthplace (State or Foreign Country)
 VA 8. Date of Birth If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Oct. 27 Year) 1907 1 🗆 M 2 🖾 F Months Days Hours Min. Director 223-92-7098 102 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State : If iten 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 ☐ Yes 2X No Mitchellville Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20721 11409 Waeche Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married be filed within 72 hours after 1 Yes 2 No Specify: Black 3 X Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Families Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental ည Hasaltine Early Thomas Gordon Holmes t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mitchellville, Md. 20721 Merle H. Richmond - Daughter 11409 Waeche Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State 6-23-2010 Wolftown, VA. Rock Hall Cemetery 4 Donation 5 Other (Specify) 21. Signature of Fungral Service Licensee Marshall s Funeral Home of Maryland Suitland, MD. 20746 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dehydration Sequentially list conditions. Examiner if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Alzheimer for use as the bunal-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death 2 X No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy , page 2 s performed? Yes 2X No 1 🗌 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes မ 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No death. Accident
Suicide Investigation 6 Could not be 2 after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated сотріете (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and itle of certifier 29c. License numbe

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

7525 Greenway Center Dr.

32. Registra s Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Darryl Hill, MD.

JUN 2 9 2010

53235

Greenbelt, MD. 20770

6/18/2010

			1 - For State Registrar	State of Mar	yland /	-	ırtment <i>tificate</i>			-	_	2010	21642
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	2 11-13						2. Date of Dea	ath		3. Time of Death
	Medic	al	Dorothy Mildre 4a. Facility Name (if not institution, give st.			- 1	4b. City To	our or Los	ation of Death	June 2		2010 Year County of Deat	2:50 a ^M
	Examin	er	Somerset Gardens As		ving				Anne			County of Deal Comerset	
	Funeral Director		5. Social Security Number 6. Sex 1 = 1 = 1	7. Age (Ir 90	n yrs. last t	oirthday) Yrs.	If Under 1 Months		Under 24 Hrs. ours Min.	8. Date of Birt 10/01/		g. Birt Cor Ma	hplace (State or Foreign intry) ryland
	id now at	Ļ	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City To	own or Loc	ation						10d. Inside City Limits
	farylar 3a-fsk iffied	ecto	Maryland Somerset	i			a Anne	<u>;</u>					1 X Yes 2 No
	ith the N 3a or 2a t be no	Funeral Director	10e. Street and Number 12360 Palmetto C	hurch Road	۹		10f. Zip C	21853	}		-	zen of What Co	untry?
	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1	Was Decedent Ever Armed Forces?		13. W	/as Deceder Yes, specify			ecify Yes or No- Rican, etc.)		14. Race - Ame	
0036	ırs after ural", or I Exami	ted by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.			☐ Yes 2				5		white
	72 hou n "natu ledica	Completed	15. Decedent's Edu (Specify only highest grade		10	(Give ki		done during	n g most of work	ing	16b, Kir	nd of Business	ndustry
212	within giene.		Elementary/Seconday (0-12)	College (1-4 or 5+)		pack	NOT use re	etirea)			Mary	land G	lass House
Maryland 21215-0036		To Be	17. Father's Name (First, Middle, Last) Charles Carl Fries	sen				18.		e (First, Middle, : e Hofbou		iurname)	
Mary	sh is	(4)	19a. Informant's Name/Relationship (Type Patricia Maher/dau		1					al Route Number g Lane,			MD 21840
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 an, injury or other tr	1. 30	20a. Method of Disposition 1 ☐ Burial 2 🏝 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ceme	etery, crema	ition (Name atory or oth	er place)		Date		cation - City or	,
Baltii	permit. P Departm Importar am injur		21. Signatul of Funeral Service Licensee				Cremand Name and		ineral 1	Home Pro		isbury, signal,	Association
			23a. Part 1. Enter the disease, or comblic shock, or heart failure. List only one	cations that caused the	_							1115 2110	Approximate Interval Between
~~	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	úscl enseguenc	eveti	ch	art	disea	يُد			Onset and Death
ميس	Examiner	-E	Sequentially list conditions.	lows	erch	lisie	rolen	nia.					20 years
	cuted nd ransit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or a co	onsequenc	:e ot):							
5	cate be executed physician and the burial-transit	edical E	resulting in death) Last	Due to (or as a co	onsequenc	e of):							
09/90	tificate ng phy as the	Med	IF FEMALE:										
POX 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	lc. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal de		Ectopic pre Other (spec				2	3d. Date of deli Month	very Day Year
7. Ö.	s that th gned by e detac	by Ph	Part II. Other significant conditions cont		not resultin	g in the un	derlying ca	use given ir	Part I.	23e. Did to	bacco us	se contribute to	the cause of death?
ras,	equires veen sig hould b	eted	serva o	min									obably 4 Dunknown
Records,	The law r ate has b page 2 sl	Completed	myperli	min						24a. Was a autop perfor	sy med?	prior to death?	opsy findings available ompletion of cause of
VItal	ician: certific ector,	Be	25. Was case referred to medical examiner?	espital:				26. Place of	of Death (Chec				
010	ig Physical this heral direction	te: To	27. Manner of Death	1 ☐ Inpatient 28a. Date of injury (Month, Day, Ye	28b	Outpatient o. Time of injury		. Injury at		ome 5 D Pesid 28d. Describe h			fy)
0	ttendin death. tor: Aft the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be				М	work? 1 Yes	2 🗆 No				
DIVISION OF	ital or Al urs after ral Direc lled in by		4 Homicide determined	28e. Place of Injury - building, etc. (S		farm, stree	et, factory, c	office		28f. Location (S City or Tow		Number or Rur	al Route Number,
	the Hosp in 24 hor he Funer ipleted fil	Medical	29a. Certifier 1 Certifying Physici 2 Medical Examine only one) 3 Certifying Nurse i	r: On the basis of exam	nination and	d/or investig	gation, in my	opinion, de	eath occurred a	the time, date ar	nd place, a	and due to the c	ause(s) and manner stated.
	North Topics		29b. Signature and title of certifier	lw em	reh,	m.D.		icense nun	nber 5384		4	signed (Month	
	SU		30. Name and address of person who com		ı (Item 23a) (Type, Pri	int)	ISIAN (ST, C	SALISR	URY	mD	21804
	Stat Registra	e	31. Date filed (Month, Day, Year) JUN 28 201	32. Fegistrar's	Signature	1	N.						,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			ForState	State of Ma	-	epartment of F		Mental Hy	giene		
			Registrar	-41		Certificate of D	<i>Death</i>		Reg. No.	2010	21643
	Physicia	n/	1. Decedent's Name (First, Middle, Lat	st)				2. Date of De Month	ath Day	3 Year Joll	3. Time of Death
	Medic		4a. Facility Name (if not institution, give	Harris street and number	2	4b City Town or	Location of Death	91		County of Death	100.06 A
	Examin	er	University of Maryle		(- 1 - 1 - 1	Beld.			40.	County of Death	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birth		If Under 24 Hrs.	8. Date of Birl	th ,	9. Birth	place (State or Foreign
	Director		579-44-4130	□ M 2 🔀 F	7.6 Y	rs. Months Days	Hours Min.	(Month, Da June	y, Year) 5 , 1 9	34 Wa	sh.,DC
	d t t		Usual Residence of Decedent 10a. State 10b. County		10c, City, Town	or Location					10d. Inside City Limits
	nylan i-f sh ied a	cto	,								1x Yes 2 □ No
	or 282		MD 10e, Street and Number	PG		Mitchellv:	ille		10a Citi:	zen of What Cou	
	vith th	al	11601 Trillum	Ctroot		2072	1	:		ted St	
	eath v	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-		14. Race - Ameri	can Indian,
ထ္ထ	fter d	ρ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 N If Yes, Give	0	If Yes, specify Cuba 1 ☐ Yes 2 🕱 No		Rican, etc.)		Black, White,	
8	urs a tural' al Ex	ted	3 ★ Widowed 4 □ Divorced	Year or Dates.	-	-				Specify: Bla	
21215-0036	if filed within 72 hours after death with the Manyland tal Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ade completed)		Decedent's Usual Occupa Give kind of work done of ife. DO NOT use retired)	ation luring most of work	ing	16b. Kir	nd of Business Ir	ndustry
7	vithin liene. rr tha the N	ខ	Elementary/Seconday (0-12)	College (1-4 or 5+))	ursing As:	sistant		st.	Elizab	eth Hosp.
73	be filed with ental Hygien ked other th ic event, the	Be	17. Father's Name (First, Middle, Last)	-			18. Mother's Nam	e (First, Middle,			
<u>la</u>	buld be filed within 7 and Mental Hygiene. marked other than matic event, the Me	유	Fred Washi	ngton			Verdel	l Nix	on		
Maryland	sh is		19a. Informant's Name/Relationship (ype, Print)		Mailing Address (Street a	and Number or Rura um Stree	al Route Numbe	r, City or	Town, State, Zip	Code)
	and 2 s Health tem 27 ther tr		Florence Mims/c	daughter	<u></u>	tchellvil	le, Md.	_20721			- 0114
Baltimore,	Page 1 anent of hant of hant; If ite		1 🔀 Burial 2 □ Cremation 3 □	Removal from State		Disposition (Name of crematory or other place	e) 7/8	710		cation - City or T	
ij	permit. Page Department Important: any injury o		4 Donation 5 Other (Special Signature of Funeral Service Licen		Md. Ve	22. Name and Addres		2 2 2 5		<u>eltenha</u>	
Ba	permit. Departr Importa any inju		21. Signal e of tuneral service Licent	divaid-		3910 Sil					
			23a. Pari 1. Enter the disease, or com	plications that caused t	he death. Do no						Approximate
-	hysician/		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	Muel	0 1 1 PM	kemia				Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of		C EVICI S				
	Examiner	L	Sequentially list conditions,	b. =====							
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to for as a	consequence of	ir.				-	
	ecuted and -trans	xan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequence of	h:					
_	icate be executed physician and s the burial-transit		rooding in doding Edot	• .		,					
760	cate l	ledical		d	,				_		
89	certif inding use a	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 🗆 Ectopic pregnanc	W.		1 2	23d. Date of deli	very
õ	death e atte	by Physician/M	in the past 12 months? 1 ☐ Yes 2 💢 No	4 Pregnant at 1		5 Other (specify)	, y			Month	Day Year
0	t the c by th tache	Phy	9 Unknown			Management of the control of the con	un in Don't				
<u>ď</u> .	s tha igned be de		Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cause give	en in Part I.				the cause of death?
rds	equire een s ould	eted	Anemia								
000	has b	Completed	Septic shock					24a. Was auto			opsy findings available ompletion of cause of
m m	n: The ficate r, pag		25. Was case referred to medical			00 0	ace of Death (Chec	1 Tes			2 XNo
/ita	sicial s certii lirecto	To Be	examiner? 1 Yes 2 No	Hospital:	at 2 \square EB/Out	patient 3 DOA Othe	or.	7	danna 6	Other (Special	5v)
o [g Phy er this ieral c		27. Manner of Death	28a. Date of injury (Month, Day,	28b. Ti	me of 28c. Injury	y at	28d, Describe			<i>y</i> /
on	adh. r: Aft	ficat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	n	rear) III		Yes 2 No				
Division of Vital Records, P.O. Box 68	r Atter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined			m, street, factory, office		28f. Location (S			al Route Number,
۵	pital o		00 0 1111 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	and a large Tarabas has a fine	l		data and other an			d mannar on stat	and .
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	iner: On the basis of exa	amination and/or	eath occured at the time investigation, in my opinion dge, death occurred at the	on, death occurred a	t the time, date a	and place,	and due to the c	ause(s) and manner stated
	To the within To the somple	Σ	29b. Signature and title of certifier	se Fractioner. To the b	BSL OF THY KNOWNE	29c. License		ce, and due to tr		e signed (Month,	
			1- PE	TO N	20	189	142_		7/=	3/10	
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (T	ype, Print)	1.1		• _/		
			Toni Biskup		Greene	St. B	salti mor	e, M	D	2120	
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1					
	negistr	. II	JUL 122	1111 / Corner	a d.	A CARLON	 				

1 DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jul 7, 2010 Nora Harris 12:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frostburg Village Nursing Home Frostburg Allegany If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day,)
Oct 3.1, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Days Hours 1 □ M 2 □ F MD 212-18-1222 Director 89 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Medical Evaminat must be notified at MD Aberdeen Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 E. Bel Air Avenue Apt. C 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc 1 □Yes 2 ■No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □ Yes 2 📉 No 2 Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilbert Cleveland Emerick Mary Lillian (Loar) Emerick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12414 Wocdcock Hollow Rd NW Mt Savage MD 19a. Informant's Name/Relationship (Type. Print) Bonnie Emerick Mt. Savage MD 21545 niece 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Seremation 3 ☐ Removal from State 7/8/2010 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of runeral Service. 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Inter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ZHEIMER MEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, they leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to Carles a consequence offi To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the huneral director, page 2 should be detached for use as the burnal-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OVSSTRUCT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No 1 ☐ Yes 2 🖼 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2♥No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

DX

DHMH 17 Rev 1/2001

Millin

SIDHUMD.

JUL 122010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

126907

BISHORWALSH RD. CUMBERLAND.

07

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2010 ROSE CECELIA HOWARD Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rock Spring Village Harford Forest Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Days Months Hours Min 214-14-4258 91 Director Usual Residence of Decedent show 10a. State notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No MD. Harford White Hall 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? other traumatic event, the Me ical Examiner must be Funeral 23a 4433 Norrisville Road 21161 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White "natural", 3 → Widowed 4 □ Divorced Specify Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Page 1 and 2 should be filed within 'ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leilich John Rose Cecelia Jager 19a. Informant's Name/Relationship (Type, Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred J. Howard 1780 Twin Oak Road Jarrettsville, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State J117 Pate 9 cemetery, crematory or other place 5 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Mem. 010 Fallston, Gardens ew 21. Signature of Funeral so ice vice 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsvi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown the NA 9 Unknown Division of Vital Records, P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 Yes 2 💢 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending NA 1 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) NA Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FSCALAN

32. Registrar's Signature

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

				ease T						. Ensure A dealth and I	-		_	
		•	For State Registrar					Ce	rtificate of	Death		Reg. No	2010	21646
	Physicia /Medic		1. Decedent's Name (First, No. 1) Jane C. I	iddle, Last) CE							2. Date of De Month June 2	Dav	Year	3. Time of Death 5:50 A M
	Examin		4a. Facility Name (If not instit	-	street and nu	ımber)				or Location of Death	1	4c.	County of Death	
	Funeral		16200 Gales Str 5. Social Security Number	6. Sex	(7. Age	(In yrs. las	st birthday)	Laurel If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	Prince C	place (State or Foreign
ı	Director		215-68-9585 Usual Residence of Deceden]M 2∏ F		83	Yrs.	Months Days	Hours Min.	December	er 12,	1926 Vir	ginia
	ryland show	_	10a. State 10b. Co	,			10c. City,		ocation					10d. Inside City Limits
	Ra-f s	Directo		nce Geo	orges		Lau	reı	101 7: 0: 1			40 0"		1 □Yes 2 No
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show afte event, the Medical Evan increment the notified at		10e. Street and Number 16200 Gales St	reet					10f. Zip Code 2070	7		USA	tizen of What Cou	nury r
	death	Funeral	11. Marital Status		12. Was Dec		ver in U.S.	13.		/ Hispanic Origin? (S an, Mexican, Puert	pecify Yes or N		14. Race - Ameri	
92	after or ite		1 Never Married 2		Armed F 1 ☐ Yes If Yes, G	2 Y No	0		1 ☐ Yes 2 X No		o nican, etc.)		Black, White, Specify: 1.71-	
Ö	hours tural",	ed by	3 Nidowed 4 □ Divo	ced dent's Educ	Year or [Dates:		16a Dece	dent's Usual Occu	nation		16b K	ind of Business/Ir	nite
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and	be file	Be	17. Father's Name (First, Mic							18. Mother's Nan	, .	e, Maiden	Surname)	
<u> </u>	should and Men s marke umatic	မ	Edgar Carter 19a. Informant's Name/Relat		ne Print)			10h Maili	na Addrass (Stree	Mildred t and Number or Ru		her City (or Town State 7	n Cade)
<u>≅</u>	and 2 s ealth ar n 27 is her trau		Cindy Ice- daug		po. i ilinj				,	Place, High				<i>p</i> 2000)
e,	of H		20a. Method of Disposition				20b. Pla		osition (Name of matory or other pla		Date		ocation - City or T	own, State
Ĕ	Pages ment of ant: If its ury or o		1 ☐ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe		lemoval from	State		_	crematory	i i	21, 2010	G1e	n Burnie,	Maryland
Baltimore, Maryland 21215-0036	permit. Page Department. Important: If any injury or		21. Signature of Funeral Ser	vice License	mo123	4		2	Fleck Fine 7601 Sandy	ral Home, I Spring Roa	NC. d, Laurel	, Mar	yland 2070	7
X 68 /6(certificate be ding physicia se as the bur	Physician/Medical Examiner	23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 ► No	List only or	Due to Due to Due to Due to	each line o (or as a o (or as a o to as a utcome o b birth 2 gnant at	conseque	nce of): nce of):	Ectopic pregnan Other (specify)	sn C	anc.		23d. Date of deli Month	very Day Year	
2	w requires that the death been signed by the atter should be detached for u		9 Unknown Part II. Other significant cor	ditions cor	9 □ Unk		t not resulti	ing in the u	ınderlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
g	law requires as been sign 2 should be	ed by									1 🗆	Yes 2	No 3□ Pro	bbably 4 ☐ Unknown
Y	The lar ate has page 2	Completed										opsy ormed?	prior to c death?	opsy findings available ompletion of cause of
VII.	Physiclan; The r this certificate h ral director, page	Be (25. Was case referred to me examiner?	<u> </u>	la anital:					26. Place of Dea	ath (Check only			
_	thys I dii	٦.	1 ☐ Yes 2 No 27. Manner of Death		lospital: 1 ☐ 28a. Date	· · · · · · · · · · · · · · · · · · ·		R/Outpatie	III 3 LI DOX		lome 5 Res		6 ☐ Other (Spec	ify)
o	Attending Ph er death. ector: After th by the funeral	tion	1 Natural 5 ☐ Pe	nding restigation	(Mo	nth, Day,	Year)	Injury	Wo	rk?]Yes 2 □No	200. 2000/100	, now inju	ny obodinou	
Division	ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After i pletely filled in by the funera	Certification: To	3 ☐ Suicide 6 ☐ Co	ould not be termined	28e. Plac	e of Injui	ry - At hom (Specify)	ne, farm, st	reet, factory, office			(Street a. wn, Stat		ral Route Number,
	e Hospita 24 hours Funeral etely filler	edical C	29a. Certifier (Check only one)	ifying Phy ical Exami	ner: On the	ne best o basis of nner stat	examination	ledge, dea on and/or i	th occurred at the nvestigation, in my	time, date and plac opinion, death occi	e, and due to thurred at the time	e cause(e, date an	s) and manner as id place, and due	stated. to the cause(s)
h	To the Hosp within 24 ho To the Fune completely fi	Me	29b. Signature and title of ce	rtifier) £6	0	2.0	D		se number Z360	1		ne ZZ	, Day, Year)
0	1/0		30. Name and address of pe							to 00010				
	Sta Registr		Edward J. Le	'ear)	32.	Registra	r's Signatu	re	parl	te G2010	COTUMDI	a, I	ID 21044	
			9911	# Z E/	,,,,	THE WAR	1	P. 19	pare					

Darius	Stanley	Johnson
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2	0	0	21	6	4	-

			1- For State Cert	tificate of Death	Re	g. No.	21047
	sicia	an/	Decedent's Name (First, Middle,Last)		Date of Deat Month	Dav Year	3. Time of Death
Medical Ex	cami	ner	Darius S. Johnson 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	June 12, 2	010 4c. County of Death	0722 hrs
			Rear of 1469 Tyler Avenue	Annapolis	Death	Anne Arundel	
Fun	eral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday) If Under 1 Year If Under		h(MM/DD/YYYY) 9. Birt	
Direc	ctor		217-06-5849 1XM 2_F	25 Yrs. Months Days Hours	Min. July	27 1984 col	Maryland
	_		Usual Residence of Decedent		· · · · · · · · · · · · · · · · · · ·		
	w any			Town or Location en Burnie			10d. Inside City Limits 1 Yes 2 XNo
yland	a-f she	햦	10e. Street and Number	10f. Zip Code	110	g. Citizen of What Coun	
те Маг	or 28; fied a	Director	6453 Union Ct.	21061		USA	
3 72 hours after death with the Maryland	or items 23a or 28a-f show must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S	6. 13. Was Decedent of Hispanic Origin		14. Race - Americ	can Indian, Black,
death	nust b	Funeral	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, F	Puerto Rican, etc.)	White, etc.	
s after	ral", c	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:			lack
hour	"natu Exan	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kir during most of working life, DO NOT us		16b. Kind of Business/Ir	ndustry
F	d other than "natural", o , the Medical Examiner n	Completed	12th 0	Cart		Sam's Clu	ıb
5-0(led wii tygier	other the M		17. Father's Name (First, Middle, Last)	18.Mother's	Name (First, Middle, M	faiden Surname)	-
D 21215-0036 should be filed within and Mental Hygiene.	arked vent,	Be	Joseph S. Johnson		na M. La		
MD 21215-0036 d 2 should be filed within 7 Ith and Mental Hygiene.	7 is m	٩	19a. Informant's Name/Relationship (Type, Print) Dianna M. Jacobs (Mother)	19b. Mailing Address (Street and Number 16453 Union Ct.		nie, Md. 2	
and 2 fealth	Important: If item 27 is marked other injury or other traumatic event, the Mc		20a. Method of Disposition 20b. P	lace of Disposition (Name of cemetery,	Date Date	20c. Location - City or	
Baltimore, bermit. Pages 1 ar Department of He	other IT		Notice LO	rematory or other place) V Moses	6-22-10	Lothian	, Md.
altin mit. P	portar ury or		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	27 Marge and ederesser Facility	ons Mort	uary, P.A	•
ന് ഉള്	E : B		Larry G. Reese Mo04/83	821 West St.	-		
Physic /M			23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.		diac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Exami		İ	Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (3) of Due to (or as a consequence of)				Death
			Sequentially list conditions, b.			مد	
		ine.	if any, leading to immediate due to (or as a consequence of) cause. Enter Underlying Cause				
	Ţ	Examiner	(Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of)	:	e 1 11.4		
executed	g physician and the burial - transit		d				
. pe ex	sician ourial	Medical	UNPENDED				
8760, ifficate be	ng phy		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the	ancy 2 Fetal death 3 Ectopic p	regnancy	23d. Date of delivery Month D	ay Year
X 68	e attending for use as	ician	past 12 months? 4 Pregnant at time of dea	2			
Box he death co	ed f	Physi	1 Yes 2 No 9 Unknown 9 Unknown	sulting in the underlying source gives in Dort	230 Did to	pacco use contribute to t	he cause of death?
P.O.	signed by	2	Part II. Other significant conditions contributing to death but not re-	suiting in the underlying cause given in Fant	·	2 ✓ No 3 Prob	
ds, equire	s peen si	Completed			24a. Was a		opsy findings available
CO law r	일시	힐	ñ		autops perfori	ned? death?	ompletion of cause of
- 8	his certificate director, page	Ŝ	25. Was case referred to medical	26.Place of Death (C	1 ✓ Yes 2	No 1 Ves	2 No
Vita ysiciau	his cer direct	B	examiner?			Residence 6 🗸 Other:	Scene
of of	After t funeral	-1	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe h Subject shot	ow injury occurred	
sion ttendi death.		atio	2 Accident Investigation Jun 12, 2010	FOUND: 1 Yes 2 V N	0		
Division of Vital Records, lal or Attending Physician: The law requires after death.	Direct of in by	ertification:	Suicide Could not be	me, farm, street, factory, office building, etc.	or Town, St	treet and Number or Rur ate) Tyler Avenue, Annapo	
Cospital Hours	uneral L	0	4 Homicide 29a. Certifier Continue Physician. To the best of my knowledge.				
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificathin 24 hours after death.	To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.				
	3 8	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
			anesz =	O.C.M.E.		June 13, 2010	
,	2	İ	30. Name and address of person who completed cause of death (Item 2		1201		
	20			11 Penn Street, Baltimore, MD 2	1201		
	81	a e	31 Date filed (Month, Day, Year) JUN 2 2 2010 32 Registrar's Signatur	park			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 2150 Ju1y Hattie Mae Jones 6 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ceci1 E1kton Elkton Care and Rehabilitation If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F Months Days Hours Min. 5,_ Virginia 218-18-9097 88 NOV 1921 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ▼Yes 2 □ No Marvland Ceci1 E1kton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 96 Elk Chase Drive 21921 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 📉 No Specify: Specify: 3 ☐ Widowed 4 🏋 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Garment Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isam Anderson Celeste Bishop 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician /Medical Examiner

The law requires that the death certificate be executed

Physician;

To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

signed by the a d be detached for

been cate has I page 2 s certificate

Box 68760,

P.O.

of Vital Records,

Division

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a State

Directo

Funeral

þ

Completed

Be

ပ

Funeral

Director

Examine burial-transi attending physician for use as the buria

IF FEMALE:

Physician/Medical

ğ

Completed

Be

၉

Certification:

Medical

(1) onall:	8.4	luks !	103 W.	Stockton	Street,	Elkton,
23a. Part 1. Enter the disease, or c shock, or heart failure. List or		ns that caused the death. Do not enuse on each line.	nter the mode of o	dying, such as cardia	c or respiratory a	rrest,
Immediate Cause (Final disease or condition resulting in death)	a	(ordrac	ore.	5		
resulting in death)		Due to (or as a consequence of):	1004	man		
Sequentially list conditions, if any, leading to immediate	b	Due to (or as a consequence of):	7	711010	24	
cause. Enter Underlying Cause (Disease or injury that initiated events	c	Hyperter	260	-		
resulting in death) Last		Due to (or as a donsequence of):				
	- 4					

3 Ectopic pregnancy

5 ☐ Other (specify)

10 Tree Lane, Elkton, MD

22. Name and Address of Facility

20b. Place of Disposition (Name of cemetery, crematory or other place)

Elkton Cemetery

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

1 Yes 2 No

20a. Method of Disposition

Rita A. Taylor/Daughter

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

1 N Burial 2 ☐ Cremation 3 ☐ Removal from State

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	art
COPO	

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown

2 ☐ Fetal death

underlying cause given in Part I.	23e. Did tobac	co use con	tribute to the cau	ise of death?
	1 ☐ Yes	2 🗌 No	3 Probably	4 🔲 Unkno

1 L	_ Yes	2 🔲 NO	Probably	4 [] Unknown
4a. Wa	as an topsy	24b.	Were autopsy fi	ndings available

1 ☐ Yes 2 ☐ No

23d. Date of delivery

Day

Year

20c. Location - City or Town, State

Elkton, MD

MD

21921 Approximate Interval Between Onset and Death

Hicks Home for Funerals, P.A.

25. Was case referred to medical

Hospital:

26. Place of Death (Check only one)						
ther: 4 Nursing Home	5 Residence	6 ☐ Other (Specify)				

1 □Yes

21921

Date July

2010

1 Yes 2 N	lo
27. Manner of Death	
1 Natural	5 Pending

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

and manner stated.

JA	4,	A Nursing H	ome	5 L. Residei	nce o	□Other	(Spe
28c.	Injury at Work?		28d.	Describe how	w injury	occurred	

5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

main St. Eleton,

29a, Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of pel completed cause of death (Item 23a) (Type, Print)

29c. License number D0060756 29d. Date signed (Month, Day, Year)

filled (Month: Day, Year)

strar's Signature Reg

State Registrar

3 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are egiple.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JR Physician/ KOEPPER 2235 M Wear I EDERICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin Hospice House Harwood, Anne Arundel Md. . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Elkridge, Md Days Hours Min **Director** 216-22-1071 83 Usual Residence of Decedent items 23a or 28a-f show er must be notified at 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1343 Jordan Drive 20764 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No USN If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc ō 1 Never Married 2 XXMarried Completed by Baltimore, Maryland 21215-0036 1 □ Yes 🐰 No 3 ☐ Widowed 4 ☐ Divorced Year or Dates. 44-46 Specify: white the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done (life. DO NOT use retired) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Flooring Mechanic Self-employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick Koepper, Sr. Edna Corola Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1343 Jordan Drive, Shady Side, Md. 20764 Elaine Martin Koepper - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State t.Lincoln Cemetery 16/25/10 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Olasta William ELTUM Physician/ disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence on) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death detached 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 2 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2/1 No Hospital 1 \square Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 24 hours after death.
Funeral Director: After this eted filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: House 1 Natural injury 5 Pending 🔲 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of contific en

State Registrar Name and address of person

31. Date filed (Month, Day, Year)

TIGHWAY

ANNAPOLIS MALIYOI

completed cause of death (Item 23a) (Type, Print)

W 445

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-04567 State of Maryland / Department of Health and Mental Hygiene Mukul Ranjn Kundu 2010 21650 Certificate of Death 1- For State Reg. No. Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1400 hrs June 16, 2010 Mukul Ranjan Kundu Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Olney Montgomery General Hospital 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Hours India 382-42-5000 Director $_{1}X_{M}$ മവ 2 F Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location any 1 Yes 2 X No Silver Spring Montgomery Maryland or 28a-f show other than "natural", or items 23a or 28a-f shothe Medical Examiner must be notified at once. death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country' 10e. Street and Number USA 14303 Notley Road 20904 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes 1 Yes 2 Y No specify: MD 21215-0036 nd 2 should be filed within 72 hours after of alth and Mental Hygiene. 4 Divorced If Yes, Give Year Asian þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) University of Maryland Professor i. Pages 1 and 2 should be filed within tment of Health and Mental Hygiene. rtant: If item 27 is marked other th or other traumatic event, the Med 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Manorama Kundu Makhan Lal Kundu Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 14303 Notley Road, Silver Spring, Maryland 20904 Ranu Kundu - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Baltimore, Permit. Pages 1 and Department of Healt 20a. Method of Disposition Baltimore Washington Crem. 1 Burial 2 X Cremation 3 Removal from State 06/22/10 Laurel, Maryland Department of Important: I Donation 5 Other Specify 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature of Funeral Service Licen 7601 Sandy Spring Road, Laurel, Maryland 20707 MO1283 ns the used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a Part I ter the disea Physician Between Onset and failure. List only on caure on each line Death /Medical a. Multiple Injuries Immediate Cause (Final Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial - transit 8 per fh g905 7-13-10 vt Physician/Medical AMENDED UNPENDED #23a.ptII.perME.G906.8/6/2010.WS The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IE EEMALE Year 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Fetal death use as past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown <u>۾</u> Atherosclerotic Cardiovascular Disease Completed of Vital Records, 24b. Were autopsy findings available 24a Was an page 2 should has been prior to completion of cause of autopsy performed death? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25 Was case referred to medical Hospital or Attending Physician; director, Be Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA this 1 Yes ۵ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death Driver auto fixed object collision Certification: Jun 16, 2010 1308 hrs Natural 1 Yes 2 ✔ No Division 5 Pending by the Investigation 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Direc 3 Suicide Could not be or Town, State) NB Notley Road @ Northwyn Drive, Silver Spring, MD determined (Specify) Major Road / Highway 4 ___ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and to

State

Assistant Medical Examiner 32. Registrar's Signature

1/else

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 18, 2010

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Victor Weedn MD JD

JUN 2 4

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			ForMEND#4a, 4b, 4c per Phy State of Maryland Former Physics (224/2010)	Depa / لا <i>Cer</i>	artment of I tificate of I	Health and Death	Mental Hyg	giene 2011	0 21651	
Di			Registrar AMO HEATTH DEPT ONH 6/24/2010 1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month.		3. Time of Death	
/N	ysicia Nedic	al	MICHAEL E KUFFEL 4a. Facility Name (If not institution, give street and number)		4b. City. Town, o	r Location of Deatl	JUNE	20 20 4c. County of De	0 / 25 4.	
Ex	amin	er	_7310 Opt zal Drive The Johns Flopkins Hospital		Bowie Baltimore	City		Prince Geo		
Fun Dire			5. Social Security Number 6. Sex 1 \times 1 \times 1 M 2 \square F 7. Age (In yrs. In Section 1) \times 1 \times 1 \times 1 \times 1 \times 1 \times 2 \square F \times 2 \square F \times 1 \times 2 \square F \times 2 \square F \times 1 \times 2 \square F \times 2 \square P \times 2 \square	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	Year) C	irthplace (State or Foreign ountry) chigan	
and			Usual Residence of Decedent	, Town or Lo	cation	,			10d. Inside City Limits	
Maryl sa-f sho	fied at	ctor	Maryland Prince George's Bov	vie					XXYes 2 □ No	
th with th 23a or 28 st be not	st be not	al Director	10e. Street and Number 7310 Quetzal Drive		10f. Zip-Code 20	0720	1	Og. Citizen of What C	ountry?	
and 21215-0036 be filed within 72 hours after death with the Maryland thal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:		
21215-0036 d within 72 hours aft giene. er than "natural", or	he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+	(Give life. [DO NOT use retire	during most of wo	rking	16b. Kind of Busines Departme Defense	•	
- a = 0	event, tl	Be	17. Father's Name (First, Middle, Last) Donald Kuffel			18. Mother's Na	me (First, Middle, I	Maiden Surname)		
Maryland d 2 should be file th and Mental Hy 7 is marked oth	umatic	၉	19a. Informant's Name/Relationship (Type. Print)					r, City or Town, State,		
e, M 1 and 2 Health em 27 i	ther tra		Carolyn Kuffel/Wife 20a. Method of Disposition 20b. Pl		Quetzal l	Drive, Bo	owie, Mar	yland 20	720 or Town State	
ialtimore, rmit. Pages 1 ar spartment of Hea	ry or o		1 Burial 2 X Cremation 3 Removal from State	emetery, cren	natory or other place. Cremator	1 - 4-			le, Maryland	
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked	any Inju once.		21. Signature of Funeral Service Licensee	• 22	2. Name and Addre	ess of Facility I	Robert E.		neral Home,	
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ente	1.4		c or respiratory arr	rest,	Approximate Interval Between Opset and Death	
Physic /Medi	ical	ĺ	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):							
Exami	ner	Jer	Sequentially list conditions, if any, leading to in mediate	inter of)						
scuted	transit	10	day, leading to in reclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conseq	iance of						
18760, Ticate be executed physician and	ne burial	edical E	d.							
I Records, P.O. Box 68760, The law requires that the death certificate be executed to has been signed by the attending physician and	or use as the	Σ	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal	death 3		су		23d. Date of d	elivery Day Year	
P.O. E at the dea by the at	ached	hysic	1	ath 5	Other (specify)					
Cords, P.O. Box 6 v requires that the death certif been signed by the attending	d be det	ک	Part II. Other significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to the significant conditions con	ulting in the u	underlying cause g	iven in Part I.	23e. Did tol		to the cause of death? Probably 4 Unknown	
Records, ne law requires the has been signed	2 shou	Completed	1 00	. 0'			24a. Was ar autops	sy prior t	autopsy findings available o completion of cause of	
	и, раде		25. Was case referred to medical			20 Diago of Day	_		es 2 🗆 No	
f Vital ysician: Th	director,	To Be	examiner?	ER/Outpatien	t 3 DOA Oth		ath <i>(Check only one</i> Jome 5 Reside	ence 6 Other (Sp	ecify)	
VISION Of VITA Attending Physician: r death. ector. After this certific	funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	ry at rk?] Yes 2	28d. Describe ho	ow injury occurred		
DIVISION OF or Attending Physics of Attending Physics of the Attention of the physics of the phy	ii by	ertification:	3 Suicide 6 Could not be determined 28e. Place of injury - At hombuilding, etc. (Specify)		eet, factory, office			tion (Street and Number or Rural Route Number, or Town, State)		
DIVISIC To the Hospital or Attendi within 24 hours af er death To the Funeral Director, A	etely fillec	O	29a. Certifier (check only one) 1 ★ Certifying Physician: To the best of my know and manner stated.	ion and/or inv	vestigation, in my	opinion, death occ	urred at the time, of	date and place, and o	fue to the cause(s)	
To the within To the	сошр	Mec	29b. Signature and title of certifier		29c. Licens	e number	2	29d. Date signed (Mo	nth, Day, Year)	
			20 Name and address of account who could be mo	23a) /Time	DOC	64099	136 ,0411.10	JUNE 21	,2010	
CA	D		30. Name and address of person who complet of cause of death (item TMSHR BLAELEY, MU ASSISTANT	PROF	ESSAN JOH	N3 HORK!	North Wol	Ife St, Baltim	nth, Day, Year) 2010 nore, MD, 21287	
Re	Sta	J	31. Date filed (Month, Day, Year) JUN 2 4 2010 32. Rigistrar's Signate	A.	race					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>10</u> Physician 8 Barbara Anne Kauffman 8:30 a Mm Julv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 25215 Marsh Manor Court Lot B Westernport Allegany 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 72 yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/02/1937 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1□M X□F 488-38-3495 Director MO Usual Residence of Decedent 10c. City, Town or Location 10a State 10d, Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Allegany 1 ☐ Yes 2 ▼No Director Westernport the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 25215 Marsh Manor Court, Lot 21562 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk State Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be file treent of Health and Mental Hy tant: If item 27 is marked oth jury or other traumatic event Be Lawrence Kauffman Kathryn Schrimpf ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Tetrick/sister 1350 Lynmar St., Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Crematory 7/9/10 20a. Method of Disposition 20c. Location - City or Town, State permit. Page:
Department or
Important: If i
any injury or once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cresaptown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Markwood Funeral Home,
P.O. Box 912, Keyser, 21. Signature of Funeral Service Licensee Inc. VV 26726 Har Keyser, WV 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician .on aestive disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** propan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed the burial-tra resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home SEPResidence 6 ☐ Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending ours after death.

neral Director: A
filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (tem 23a) (Type, Print) 30. Name and addre Melissa . Loya, M.D. 167 S. Mineral St., Keyser, 26726 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 35 MARK HENLEY KOEHL July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick MemorialHospital Frederick Frederick g, Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 X M 2 🗆 November 28. 218-82-2334 Maryland 49 Yrs Director Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location with the Maryland the Medical Examiner must be notified at Director 28a-f 1 Yes 2 X No Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò United States of America Funeral 21702 items 23a 5301E Shookstown Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 2 X No ρ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Framing Contractor Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ဂ္ Grace Free Joel Koehl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5301E Shookstown Road, Frederick, Maryland 21702 Leanna Duvall Koehl / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State July 10, 2010 Frederick, Maryland Rocky Springs Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Keeney & Bastord P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 21. Signature of Funeral Service Dicen M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician Metastatu Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year be detached for Pregnant at time of death 5 Other (specify) 9 Unknown g 🗌 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 3 Probably 4 ☐ Unknown 1 Yes 2 🗌 No Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No ည 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🔲 Yes 1 Natural 5 Pending s after death.

Director: Aft 2 🗌 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Maar)

316

MDD 70559

74h St

Frederick, mo

010

Sevet

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

400

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ned B. Lucas 2010 June 10:15pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 830 Little New York Rd. Rising Sun Ceci1 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 ▼ M 2 □ F Sept 9 1919 90 Yrs. Director 214-18-7031 Usual Residence of Decedent show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Ceci1 Rising Sun 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21911 USA 830 Little New York Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces' OF 1 1 Never Married 2 X Married Completed by 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 1941-45 other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed tment of Health and Mental Hy rtant; If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) မ Emma V. Hutchens Clay S. Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 Little New York Rd. Rising Sun, MD 21911 Doris Lucas / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 6/29/2010 1 \square Burial 2 $\overline{\mathbf{M}}$ Cremation 3 \square Removal from State Department of Important; If any injury or R.T. Foard Funeral Home, P.A. 4 Donation 5 Other (Specify) Rising Sun, MD 21. Signatur of Funeral Service Licensee Name and Address of Facility T. Foard Funeral Home, I S. Queen St. Rising P.A. 23a. Part 1. Enter the disease, or complic ations that ca used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only or Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. thany leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to forces a posterous con-Exam that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy
 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown ed by the a 1 ☐ Yes 2 ₹ g ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician; The law requires cate has been sig page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate Yes 25. Was case referred to prical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Man of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 + 1 VM 620 StAnton Christiana Rd Newark De 19713 Ford Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 9 2010 Registrar

DHMH 17 Rev 7/2009

10-04933 Wesley Lee Liller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amond State of Maryland / Department of Health and Mantal Hygiene

		1-For State Amend Items 45,281 per me, 2906, Certificate of L	Death	, Reg. I	2010 No.	2165
Physic Vledical Exam		Decedent's Name (First, Middle, Last) Wesley Lee Liller		2. Date of Death Month Da July 1, 2010		3. Time of Death 0830 hrs
			City, Town, or Location of Deat		4c. County of Death Allegany	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 212-94-6917 1 M 2 F 44 Yrs.	If Under 1 Year If Under 24Hr Months Days Hours Mi		MM/DD/YYYY) 9. Birth Foreign Cour	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
e Maryland or 28a-f show <u>Ged at once.</u>	ţ.	MD Allegany Rawlii				1 Yes 2 No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Maryland than Maryland than Maryland shard Mygiene. This marked other than "natural", or items 23a or 28a-f sho martic event, the Medical Examiner must be notified at ones.	Director	20604 McMullen Highway	Of. Zip Code 21557	10g. (Citizen of What Count USA	ry?
pe as	Funeral		Decedent of Hispanic Origin? (S specify Cuban, Mexican, Puert		14. Race - America White, etc.	
ırs after (tural", o	\$	3 Widowed 4 Divorced If Yes, Give Year 1 Yes	es 2 No specify: Usual Occupation (Give kind of	work done 16	Specify: White	
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death rt of Healin and Mental Hygiene. It If Item 27 is marked other than "natural", or ite other fraumatic event, the Medical Examiner must	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most	of working life. DO NOT use re			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		12 Wareho	ouse dept. 18. Mother's Nam	e (First, Middle, Maid	New Page len Surname)	Corp.
2121 ould be f I Mental s marked ic event,	To Be	Charles Liller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Haze ddress (Street and Number or	el (Malone Rural Route Number) Liller , City or Town, State, 2	Zip Code)
ore, MD 21215-0036 ss 1 and 2 should be filed within 72 of Health and Mental Hygiene. If liem 27 is marked other than her traumatic event, the Medicial		Joyce Liller Wife 2060 20a. Method of Disposition 20b. Place of Disposition	14 McMullen Hig		ings oc. Location - City or T	MD 21557 own, State
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		1 X Burial 2 Cremation 3 Removal from State crematory or other 4 Decremation 5 Other, Specify: Biertown Ceme		7/6/2010	Rawlings	MD
Baltimo permit. Pago Department Important:		2. Signature of Funeral Surviva Licensee 22. Nam	ne and Address of Facility Scarpelli Funeral I	Home, PA		
Physician /Medical		23a. Part I. Enter the disease, of complications that caused the death. Do not enter the realiure. List only one cause on each line.			nd, MD 21502 shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Chlorpheniramine & hydrograms of the condition resulting in death) Due to (or as a consequence of):	rocodone intox	ication		Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
cecuted and - transit	Examin	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			•	
ਬ ਬ	edical	X UNPENDED AMENDED 23a,27,28a-f,per ME	g905 7/22/10 T	T		
OX 68 ath certification attending or use as	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal (23d. Date of delivery Month Da	y Year
that the denoted by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		co use contribute to th	
rds, P.C requires that been signed b				1 Yes 2	24b. Were auto	bly 4 Unknown psy findings available
Records, The law require	Completed			autopsy performed 1 Yes 2	? death?	mpletion of cause of
of Vital Recong Physician: The Mer this certificate need director, page	o Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check DOA Other Nursin		idence 6 🗸 Other: 9	Scene
n of ding Ph. After t funeral	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	y 28c. Injury at Work?	28d. Describe how subject t	injury occurred	uch cold
Division To the Hospital or Attendii within 24 hours after death. To the Funeral Director. /	ertification:	2 X Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fi	am —	& pain med 28f. Location (Stree or Town_State)	dication 20604 McM	I Route Number, City
Di Hospital 24 hours a Funeral I tely filled	cal Cer	4 Homicide determined (Specify) House 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place, and	Cumperram	ti, MD	
To the Howithin 24 to To the Funcompletely	Medic	one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated. 29b. Signature and title of certifier	in my opinion, death occurred a		place, and due to the	
		and.	O.C.M.E.	,	uly 2, 2010	, ,
-		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 2120	1		
S	ate	31. Date filed (Month, Day Year) 32. Registra's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 21656 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jul 3 3:45 PM Lindner Sarah Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs Funeral Months Hours Min Feb 16. 1957 Director 212-76-3613 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits event, the Medical Examiner must be notified at 10c. City, Town or Location Director Silver Spring MD Montgomery 1 XYes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 20904 718 Tanley Road USA items ; 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Direct Selling Assoc. Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hy, Important: If item 27 is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth (Fullbright) Feeney Hubert J. Feeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 621 Montgomery Avenue Cumberland MD 21502 William Feeney brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date St. Mary's Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 7/8/2010 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / Funeral Se / PLicensee 22. Name and Address of Facility Paral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part/1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a Acute Left Middle Medical Due to (or as a consequence of Examiner Days Embolic Stroke Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Diwito for as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Acute Myocardial Infarction Days that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Weeks Cholangiocarcinoma Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant a 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonary Metastases, Hypertension 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပု 1 🕰 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Investigation 6 Could not be Accident Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

OHMH 17 Rev 7/2009

State

Registrar

32. Regist ar's Signature

Barbara Supanich RSM MD 1500 Forest Glen Rd. Silver Spring, MD 20910

arko

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State of Maryland		artment of H <i>tificate of D</i>			ene 2010	21657
Dharia		Decedent's Name (First, Middle, Last)				2. Date of Death _Month	1	3. Time of Death
	dical	A SECURE AND ASSESSMENT OF A SECURE ASSESSMENT ASSESSME	on	4) Otto Town and	La cation of Dooth	June	25, 2010	
Exam	niner	4a. Facility Name (if not institution, give street and number) Abbey Manor		4b. City, Town, or t La Pla			4c. County of De	
Funera	al	5. Social Security Number 6. Sex 7. Age (In yrs. las		if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	year) 9. B	irthplace (State or Foreign country)
Directo		577-01-6461 100 Usual Residence of Decedent	Yrs.		Noven	ber 23,	1909 Was	shington DC
land show	į	10, 0	, Town or Loc	cation	-			10d. Inside City Limits
e Mary r 28a-i notifie	بَا	MD Charles	Cobb 1	Island 10f, Zip Code			0g, Citizen of What 0	1 Yes 2 No
with the 23a or	Funeral Director	14913 Potomac River Drive		206	25		USA	Sound y :
IBNG 21215-UU30 be filed within 72 hours after death with the Maryland lental Hygiene. rked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	I I		. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Orlgin? (Spe	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	nerican Indian, lite. etc.
after all, or Examir	2	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates,	1	☐ Yes 2 🛣 No	Specify:		Specify:	White
hours hatura	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ition	na I	16b. Kind of Busines	s Industry
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Maryland 21213-0036 2 should be filed within 72 hours after tht and Mental hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	B B	17. Father's Name (First, Middle, Last)	ACC	Countaire	18. Mother's Name	e (First, Middle, N		.010
yfan Id be fi Menta arked atic ev	F	Gustave L. Glotzbach			Maude A	. Glotz	bach	
Mar 2 shou h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)					City or Town, State, 2	Zip Code)
re, r 1 and 2 f Healt item 2			lace of Dispo	Box 444, sition (Name of			20625 20c. Location - City	or Town, State
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Baltimore, IMaryland 21213-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ouce,	21. Signature of Funeral Service Licensee M00094	¥5 22	AREHARITE				10646
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3760 ificate b ig physia as the b	Modical	G						
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P.O. s that the gned by to e detach	2		ulting in the u	ınderlying cause giv	en in Part I.			to the cause of death?
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eco le law r e has b ige 2 sl	Completed		-7			24a. Was a autops perfon	sy prior t med? death	to completion of cause of
al R ian: Th rtificate rtor, pa	000	25. Was case referred to medical		26. Pla	ace of Death (Checi			
F Vit	F	1 Yes 2 A No 1 Inpatient 2	ER/Outpatier		er: 4 Nursing Ho	ome 5 Reside	ence 6 Other (Spow injury occurred	ssisted iving
on of		26. Date of Injury 1 Set Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	work	Yes 2 No	28a. Describe no	ow injury occurred 2	27.77.8
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific: within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending Formpleted filled in by the funeral director, page 2 should be detached for use as	2	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At ho building, etc. (Specify,		eet, factory, office		28f. Location (St City or Town	reet and Number or i	Rural Route Number,
Divital of ours af ours af erral Divited in filled in	100		edge, death	occured at the time.	, date and place, ar	nd due to the cau	se(s) and manner as	stated.
he Hos in 24 h he Fur ipleted	Modioc	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner. To the best of my	n and/or inves	tigation, in my opinic	on, death occurred a	t the time, date ar ce, and due to the	id place, and due to the cause(s) and manner	ne cause(s) and manner stated. as stated.
To t With		29b. Signature and title of certifier	-	29c. License	umber 457		29d. Date signed (Mo June 28	
		30. Name and address of person who completed cause of death-(flem	1 23a) (Type, I		(- /	- /		
BBS		Jayanthan Nirmaldevi, M.D. 3328	8 01d 1		n Rd. Wal	Ldorf,MD	20603	
S Regi:	State strar		d. A	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 - State Registrar Amend#5perfuneralhome6/28/10cehricate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NALDORA 3592 Old Washington Road Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Min. V York 053-20-38123 Director (New Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland irnent of Health and Mental Hygiene. Rant: If item 27 is marked other than "natural", or items 23a or 28a-f shoilury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Aldor 1 X Yes 2 No $\mathcal{N}\mathcal{D}$ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral NAShina USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) J Mental Hygiene. marked other than "I matic event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) Commercial 12 Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Daniel Sawaya Marjorie Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) \$592 Old Washington Road Waldorf, MD 20602 Ray Merrill/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 Durial 2 Cremation 3 Removal from State Atlantic Crematory 6/26/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications the caused the distance and ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each films. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or linjury burial-trans that initiated events resulting in death) Last and physician Physician/Medical Records, P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No ģ Month Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed' Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I To the Hospital or Attending Physician: 25. Was case eferred to m Division of Vital Be 26. Place of Death (Check only one) examiner Other: 2 No 1 Yes မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: Matural Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) title of certifier

State

State ⁸ Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Rygistrar's Signature

te 100 Weldort

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State State Registrar	of Maryland / Dep Ce	ertificate of Death	Mental Hygi	ene g. No. 2010	21659
	Dhusisi		1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Flora Barbara Morton			June	18, 2010	1:55 A M
	Examin	er	4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Dea	ath	4c. County of Death	
1			7106 Laverock Lane		Bethesda If Under 1 Year If Under 24 H	70 L 0 D-11 - (D: 1)	Montgomer	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday 82 Yrs.	Months Days Hours Mi	n. (Month, Day,	Year) 9. Birting	place (State or Foreign
	Director	ļ	220-36-7286 Usual Residence of Decedent	82		Jan 14,	1928	England
	land ow		10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits
	Mary 1-f sh	햦	MD Montgomery	Bethesda				1 ☐ Yes 2 🔀 No
	h the	Director	10e. Street and Number	- Journal of the	10f. Zip Code	10	g. Citizen of What Cour	ntry?
	th wit	ig ig	7106 Laverock Lane		20817		United Sta	tes
	dea	Funeral		ecedent Ever in U.S. 13 Forces?	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Americ Black, White,	
36	after or it	F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Ye	es 2 ⊠ No	1 ☐Yes 2 ☑ No Specify:	,	Specify: Whi	
00	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show deal Even for must be instiffed at	d by	3 kg Widowed 4 ∐ Divorced Year o	or Dates:	**			
		Completed	15. Decedent's Education (Specify only highest grade complete	ed) (Giv	edent's Usual Occupation e kind of work done during most of w DO NOT use retired)		6b. Kind of Business/In	uusiiy
12	E S E		Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	Bioethic	ict	Non Profit	Educational
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an	0 to 0 to 0	To Be	Christopher Hug	hes	Flora	Hughes		
Maryland	2 should and Mer is marke aumatic	-	19a. Informant's Name/Relationship (Type. Print)		ling Address (Street and Number or		City or Town, State, Zip	Code)
	od 2 z7 is r tra		Andrew Orlans/Son	74	63 John Marshall	Highway,	Marshall,	VA 20115
Baltimore,	es 1 ar of Hea fitem rothe	1 3	20a. Method of Disposition	20b. Place of Disp cemetery, cri	position (Name of ematory or other place)	Date 2	20c. Location - City or To	own, State
<u>Ĕ</u>	Pages nent of ant: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	Fort Li	ncoln Crematory	6/24/10	Brentwood,	Maryland
alt	permit. Pages Department of Important: If It any injury or conce.		21. Signature of Funeral Service Licensee	101703	22. Name and Address of Facility	Simple Tr		
<u> </u>	80 E 2 9		eyso,		040 Rockville Pil			
			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not e on each line.	nter the mode of dying, such as card	iac or respiratory arre	est,	Approximate Interval Between Onset and Death
S.	Physician		Immediate Cuse (Final disease or condition a. Con	gestive Heart	Failure			
4	/Medical Examiner		resulting in death)	to (or as a consequence of):				
		F	Sequentially list conditions, b.	to (or as a consequence of):	•			
	uted d insit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,				
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8760,	ficate be executed physician and s the burial-transit	dicat	d					
	rtifica ng ph as th	Medi	IF FEMALE:	· · · · · · · · · · · · · · · · · · ·				
Box	death certific e attending p d for use as	an	23b. Was decedent pregnant 23c. If yes,	outcome of pregnancy ive birth 2 Tetal death 3	☐ Ectopic pregnancy		23d. Date of deliver Month	ery Day Year
O.E	0 0 0	Physician/Me	1 DYes 2 No 4 P		Other (specify)		World	Day Teal
<u>P</u>	that the de ned by the a detached i	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to	to dooth but not regulting in the	underlying course given in Part I	23e Did toh	pacco use contribute to	he cause of death?
Š,	es gi	ð	Fart II. Other significant conditions continuing	to death but not resulting in the	underlying cause given in rait i.		s 2 □ No 3 □ Pro	
Vital Records,	w requir been si should I	Completed				-		
3ec	e law has t	햩				- 24a. Was ar	y 24b. Were auto y prior to co ned? death?	opsy findings available ompletion of cause of
		ပိ				perform 1 □ Yes 2		2 🗆 No
Vit		Be	25. Was case referred to medical examiner? Hospital:		0.00	eath (Check only one		
of		5	I Tes Z HO	Inpatient 2 ER/Outpati	ent 3 DOA 4 Nursing	28d. Describe ho	ence 6 Other (Spec	ify)
on	ding Ph h. After th funeral	ţi	1 Natural 5 ☐ Pending (1 2 ☐ Accident investigation	Month, Day, Year) Injury				
Division	Attending r death. ector: Afte by the fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. P	lace of Injury - At home, farm, s	street, factory, office		reet and Number or Rui	al Route Number,
É	al or , after s after l Direct d in t	Certification:	4 ☐ Homicide determined b	uilding, etc. (Specify)		City or Town	i, State)	
	ospita hours mera y fille		29a. Certifier 1 Certifying Physician: To	o the best of my knowledge, de	ath occurred at the time, date and pl investigation, in my opinion, death o	ace, and due to the ca	ause(s) and manner as	stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical	one) and r	nanner stated.				
	Vitt Con	Σ	29b. Signature and title of certifier		29c. License number	29	9d. Date signed (Month	, ∪ay, Year)
	5		Stem Wall	s mo	D0063195		6/22/10	
			30. Name and address of person who completed		e, Print) 1 8600 Old Georgt	own Rd R	ethesda MD	20851
						.cwii Ku, De	circada, rib	
	Sta Registr		JUN 2 5 2010	2. Registrar's Signature	Ked.			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2010 Ernest Fredrick Miller Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4438 Hoopers Neck Road Taylors Island Dorchester Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Min Aug. 8. 1X M 2 F 214-28-4014 74 1935° Maryland **Director** Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director MD Dorchester Taylors Island 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4438 Hoopers Neck Road 21669 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 white 1 ☐ Yes 2 No Specify. Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) organizer union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lee Dorset Miller Jessie Laverne Landon i and 2 should be the Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Willey daughter P. O. Box 14, Taylors Island, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ott cemetery, crematory or other place) 1 🖫 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Old Trinity Churchyar**ḍ** 6/30/10 Church Creek, MD 21. Signature of Runeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Keyro 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cays on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Įo, Pregnant at time of death Month Day Year by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, ەلانىڭ 2 3 Probably 4 Unknown 1 A Yes been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Dea h 28a. Date of injury 28b. Time of ë 28c. Injury at 28d. Describe how injury occurred Funeral Director: After (Month, Day, Year) injury 1 Natural 2 Accident 5 \square Pending Certificat death. 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

emmite

JUN 29 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Christine Almond Middleton June 24 2010 10:45 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4025 Foreston Road Beltsville Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours Country) t. Rainier,MD 1 M 2 K F Min. (Month, Day, Yea, 3/6/1911 578-26-8479 Director 99 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4025 Foreston Road 20705 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) o. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Washington Sub (WSSC) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administration Sanitary Commission marked other Be 17. Father's Name (First, Middle, Last) snould be file th and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Christopher Columbus Almond Daisy Leona Langley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra William A. Middleton / Son 232 Ironshire South, Laurel, MD 20724 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 7/7/2010 Brentwood, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Coronary Artery Disease years Medical resulting in death) Due to (or as a consequence of Examiner Myocardial Infarction Sequentially list conditions, if any leading to immediate Due to for as a consultience of cause. Enter Underlying Cause (Disease or iinjury Exami or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🗵 No Day Pregnant at time of death Month Year the detached Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hypertension 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has s certificate has lirector, page 2 performe death? Yes 2 X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 A Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completed filled i Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0012121 June 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year,

JUN 2 9 2010

George F. Sengstack, 3929 Ferrara Drive, Wheaton, MD

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JOHN STEPHEN MARSHALL Physician/ JULY 3, 2010 Year 6:50P Medical Facility Name (if not institution, give street and number)
NORTHWEST HOSPITAL Examiner BALTIMORE CO. RANDALLSTOWN . Social Security Number 219-72-4488 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birtl 9. Birthplace (State or Foreign **Funeral** Hours 1**X** M 2 □ F 51 7^{Mo2th}3^{Day}1^Y9³⁵8 WASH., D.C. Director Usual Residence of Decedent show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD. PRINCE GEORGES ACCOKEEK 1 🗆 Yes 2 🎽 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1508 AIRPORT LANE 20607 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 XNever Married 2 Married Completed by 1 Yes 2 2 X No Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: SpecifyWHITE "natural", 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natur ury or other traumatic event, the Marcial I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) HOUSE PAINTER SELF EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT ERNEST MARSHALL, SR. GLORIA JEAN JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT E. MARSHALL, JR.-BROTHER 40362 DOCKERS DR. MECHANICSVILLE, MD. 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or METROPOLITAN CREMATORY 7-8-10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 21. Signature of For eral Service License MQ0479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. leading to immediate cause. Enter Under or impurity ing Cause (Disease or iinjury Dus to for as a consequence off Exami anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for L in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Other (specify) Year 4 Pregnant Pregnant at time of death 1 Yes 2 9 Unknown s been signed by the should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 sl autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗔 only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar 30. Name and addre

31. Date filed (Month, Day, Year,

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of person who completed cause of death (Item 23a) (Type, Print)

MYD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE Mabel Martin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMRM umber (AND If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Bithplace (State or Foreign Country) MO 1 - M 2 - X Mov[#]1 ^{Year}924 Director 488-24-0496 85 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Exa<u>miner must be notified at</u> 10d. Inside City Limits Director MD Allegany Mt. Savage 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17105 Martin Lane NW 21545 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ■Widowed 4 □ Divorced Completed white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) caferteria worker School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orval Vandiver Elsie Mae (Upshaw) Vandiver 19a. Informant's Name/Relationship (Type, Print) ^{19b.} Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 17105 Martin Lane NW Mt. Savage permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau MD 21545 Carol Miller daughte 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Savage Methodist Cemetery 7/2/2010 MD Mt. Savage 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig Jure of Funeral Service of see 22. Name and Action of Fulf Printeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ORONANY disease or condition Medical resulting in death) Due to (or as a consquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami Due to (or as a consequence of) g physician are the bunal-t resulting in death) Last Physician/Medical equires that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. has been signed c 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Repords, 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy page 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 1 No မ 1 Dimpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registry's Signature

29c. License number

121244

TREET FROSTRURG

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:30 PM 2010 July 3 LILACE MARY MARTIN /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Pylesville Harford 4903 Rocks Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dav. Year) **Funeral** Months Days Hours 1 □ M 2 🖳 F Yrs Director 97 North 218-14-8970 10/19/1912 Carolina Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Exprimer must be notified at Director 1 Yes X X No Harford Pylesville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21132 4903 Rocks Road United States Funeral within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 Specify: White 1 ☐ Yes 2 ☐No Specify. 9 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own home 12 Homemaker **Baltimore**, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be then tof Health and Mental is marked Emma McMillan ဥ Jacob Vaught 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau once. <u>Samuel M. Martin/Son</u> 4933 Rocks Road, Pylesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Symmation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Eagle Crem. 7/5/10 Leola, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 00 23a. Part 1. Enter the disease, or composhock, or heart failure. List only lightions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovaso ¹ Physician 2 WOOK /Medical Examiner Se juentiall, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician the burial Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☑ No Day Year 5 ☐ Other (specify) o. the 9 Unknown 9 Unknown signed by i ۵, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Tes 2 **N**0 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes Hospital or Attending Physician: after death.

Director: After this certific
In by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manne of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled e Funeral 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

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completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certified (10 DOO 5609/ July, oy, 200 (Type, Print) Bata Bouleward/Suile A, Belcamp, Maryland 21012

Registrar DHMH 17 Rev 1/2001 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21665 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:45 PM Mosier Daryl Gene 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany 205 Arch Street Cumberland 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MI 1 □ M 2 □ F ^{(KSrep}7, 1956 Director 218-60-1455 53 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 205 Arch Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black. White, etc. 1 ☐ Never Married 2 ☐ Married ğ 2 No 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 1974-1977 white Completed 3 Widowed 4 Divorced Year or Dates rnit. Page 1 and 2 should be filed within 72 hour earment of Health and Mental Hygiene. cotant: If item 27 is marked other than "natur i hilury or other traumatic event, the Medical in hilury or other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) carpenter Carpentry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Madeline (Hennan) Mosier Cecil Mosier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 205 Arch Street Cumberland MD 21502 Deborah Mosier Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Permation 3 Removal from State Scarpelli Funeral Home, P.A. 6/29/2010 Cresaptown MD 4 Donation 5 Other (Specify) permit.
Departing ords
any inju Sianature of 22. Name and Address III Full Yeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a co auence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death detached 9 Unknown 9 Unknown as been signed by the 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy filled in by the funeral director, page 2 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tyes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 2 Accider
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar e and address of per

31. Date filed (Month, Day,

STE 301 CUMBERLAND

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month L 6-14 2917 ICHARM MILL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death Examiner BALTIMORE C114 JAMAR. TAN HOJPITAL If Under 1 Year | If Under 24 Hrs 7. Age (In yrs, last birthday) Yrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months MARCIT Country) 22016220 Director Maryland Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location at Director notified 1 Yes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a or Examiner must be Funera 8052 Ball Road United States death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 🔀 Yes 2 🗆 No Black, White, etc. 1 Never Married 2 Married 1 X Yes If Yes, Give "natural", or þ Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed 3 X Widowed 4 Divorced Year or Dates. WWII the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 9 <u>parts_vendor</u> <u>antique cars</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ဂ္ William Miller Myrtle Jane Mullinix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Alice Stup/ daughter Ball Rd., Frederick, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/9/2010 Frederick, Maryland Mt Olivet Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Keeney & Basford Funeral Home Jaquelle Kre MO1222 106 Ε. Church St. Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line and Death Immediate Cause (Final CARDIOGENIC Priysician disease or condition resulting in death) 144 Medical Due to (or as a consequence of): Examiner N 66 Sequentially list conditions any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine sician and burial-transit AORTIC REGURGI that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis mpleted filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Yes g Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NAL Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Ves 2 No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Name of the stat ဖြ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? **X**Natural 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29d. Date signed (Month, Day, Year)

State Registrar 12+DHMH 17 Rev 7/2009

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29b. Signature and title of certifier

30. Name and address of person

2112

31. Date filed (Month, Day, Year)

ause of death (Item 23a) (Type, Print)

5601

NNO

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VEN BLUY. BALIMORS

010

Hospital or Attending Physician: 24 hours after death. within 24 hours at To the Funeral D completely filled

DHMH 17 Rev 1/2001 OCME 2006

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Medical

State

Registra

29b. Signature and title of certifie

Russell Alexander MD.

11 11

31. Date filed (Month, Day, Year)

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

barra

30. Name and address of person who completed cause of death (Item 23a)

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Dadult.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 2, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23^{Day} June 20 TO ALLEN S. NEWBILL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 2219 Afton St. Temple Hills Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 29, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Min. Director 223-48-1899 Dec. Usual Residence of Decedent shov 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10d. Inside City Limits Director must be notified 28a-f 1 Yes 2x No MD Prince Georges Temple Hills ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2219 Afton St. 20748 USA ral", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. P. Completed by 1 Never Married 2 X Married 1 Yes 2 🛚 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Divorced 4 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ced other than " cevent, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 10th Long Distance Driver Mayflower Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked of other traumatic ever ၉ Thelma Francis Newbill unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lanham, MD. 20706 2802 Pinoak Lane Mattie Newbill-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 6-29-2010 Suitland, MD. Signature of Furgeral Service Licenses Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stomach Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Die to (or as a nonsequents of): if any leading to in rectart cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eled filled in by the funeral director, page 2 should be detached for use as the burial-transit lead filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death this certificate has been signed by the ral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 1 Tes 2 XNo ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prectioner: to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prectioner: to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prectioner: to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prectioner: to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prectioner: to the basis of examination and/or investigation.

CA 1

Martin Weltz, MD 7525 Greenway Center Dr.

31. Date filed (Month, Day, Year)

JUN 2 9 2010

Serving Signature

JUN 2 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State

Registrar

29c. License number

Greenbelt, MD. 20770

D23743

29d. Date signed (Month, Day, Year)

June 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryla		rtment of Health ar tificate of Death	Re	g. No. 2010 21669	
	Physici /Medic		Decedent's Name (First, Middle, Last) AUDREY VIVIAN NAZELROD			2. Date of Death Month JUNE	Day Year 22:15 M	
or and the state of the state o	Examin		4a. Facility Name (If not institution, give street and number) 100 HONEYSUCKLE LANE		4b. City, Town, or Location of I	Death	4c. County of Death ALLEGANY	
	Funeral Director			s. last birthday) . Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min. B. Date of Birth (Month, Day, FEB. 3,	Year) 9. Birthplace (State or Foreign Country) MARYLAND	
	f show	or		City, Town or Loc		-	10d. Inside City Limits 1	
	h the N or 28a-	Director	MD ALLEGANY 10e. Street and Number	FROSTE	10f. Zip Code	10	Og. Citizen of What Country?	
	23a c	ral	100 HONEYSUCKLE LANE		21532		U.S.A.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Medical Examiner russi be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	17	Vas Decedent of Hispanic Origin Yes, specify Cuban, Mexican, F ☐Yes 2 X No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE	
21215-0036	within 72 hou lene. than "natura tre Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0.12) College (1-4or 5+)	(Give I	ent's Usual Occupation kind of work done during most o OO NOT use retired)		6b. Kind of Business/Industry	
	filed wil Hygien other th		12	HOM	EMAKER	s Name (First, Middle, M	HOME	
Maryland	should be filled v nd Mental Hygie : marked other t umatic event, in	To Be	17. Father's Name (First, Middle, Last) WILLIAM JONES		LOTT	IE WILLIAMS	3	
Mar	12 shou h and M 7 Is mar traumat		19a. Informant's Name/Relationship (Type. Print)		-		City or Town, State, Zip Code)	
di.	s 1 and 2 of Health item 27 I		BETH CLARK / NIECE 20a. Method of Disposition 20b.		SANNAH STREET, sition (Name of hatory or other place)		MD 21532 20c. Location - City or Town, State	
E E	Pages nent of int: If it		1 Burial 2 Cremation 3 Hemoval from State	-	MEML. PARK 06	/29/2010	FROSTBURG, MD	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signeture of Funeral Service Licensee			Hafer Funer	ral Service, P.A. Wale, MD 21502	
,8760,	Physician Medical Physician and	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consection of the conditions of the cause) of the conditions of	equence of):	ng ng ja	tory in	Onset and Death Onset and Death	
O. Box 6	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DNO 9 ☐ Unknown 23c. If yes, outcome of pregnant at time of 9 ☐ Unknown		23d. Date of delivery Month Day Year			
rds, P.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death but not re	sulting in the un	derlying cause given in Part I.		s 2 No 3 Probably 4 Unknown	
al Records,	n: The law requir ficate has been s r, page 2 should	Completed				1 ☐ Yes 2	opsy prior to completion of cause of death?	
of Vital	Physician: r this certificaral director, p	o Be	25. Was case referred to edical examiner? 1 Yes 2 7No Hospital: 1 Inpatient 2	☐ ER/Outpatien	Othor	of Death Check only one	ence 6 Other (Specify)	
ion of	ding After fune	Certification: T	27. Manner Death 1 Date of Injury 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		28d. Describe ho	w injury occurred	
Division	al or Atte s after des al Directo ed in by th	Sertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office	28f. Location (St. City or Town	reet and Number or Rural Route Number, o, State)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	n occurred at the time, date and vestigation, in my opinion, death	place, and due to the conoccurred at the time, do	ause(s) and manner as stated. ate and place, and due to the cause(s)	
	To t	Σ	29b. Signature and title of certifier	n	29c. License number	8/	Oure 26 2010	
			30. Name and address of person who completed cause of death (Ite Dr. Gary L. Wagoner MD, 925 B	em 23a) (Type, Bishop W	Valsh Dr., Cumb	erland, MD	21502	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sign	12	Miller Ger			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OLDLAND 2010 11:00A M ROY RICHARD APRIL 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death CHARLES WALDORF 4279 DRAKE COURT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number Days 1 XM 2 ☐ F WASHINGTON, DC 50 DEC.21,1959 578-92-3129 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □ Yes 2X XVo CHARLES WALDORF 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U. S. A. 20603 4279 DRAKE COURT 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify:WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MD NATIONAL CAP. Elementary/Secondary (0-12) College (1-4or 5+) PARKS & PLANNING CARPENTER 12 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROSE MARY REINHARDT DELBERT OLDLAND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1624 ACCOKEEK RD., W., ACCOKEEK, MD 20607 ANNA PARKER/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State CLINTON, MARYLAND RESURRECTION CEM. 4-14-2010 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility RAYMOND FUNL SERVICE, P. A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one s that caused the death. on each line. such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Yea 5 Other (specify) Other significant conditions uting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vies 3 Probably 4 Unknown 2 No

Physician /Medical Examiner

Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "naturai", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

12 should be filed with and Mental Hygier7 is marked other th

permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traur

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed aftending physician and for use as the burial-tran been signed by the should be detached page 2 should has certificate Physician: funeral director, After this

Box 68760.

P.O.

Division of Vital Records,

To the Hospital or Attending

death

the

filled in by

completely

within 24 hours after death To the Funeral Director:

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 1 ☐Yes ₽ No

25. Was case referred to medical 1 ☐ Yes 2 No 27. Manne of Death Natural 2 Accident

3 Suicide

4 Homicide

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 04 63 2010 investigation

28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

28f. Location Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one

29b. Signature and t

5 Pending

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

CAMILLE WOODSON, M.D., 900 E.SWAN CREEK RD.FT. WASHINGTON, MD 20744

Registrar

31. Date filed (Month, Day, Year) JUN 17

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:25 PM M 2010 J_{u}^{Molth} 6, Barbara Lee Ozag Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Mt. Airy Kline Hospice House 8. Date of Birth Sept. 10 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 TyF 1932 Pennsylvania 77 Director 208-24-8054 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Frederick 1 Tes 2 XNo Maryland Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. Funeral 21702 8203 Greenvale Drive within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent/Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rose Bailev John J. Brady, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Birmingham Drive, Frederick, MD 21701 Dr. David Ozag, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery July 10, 2010 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney and Basford PA_Funeral Home MO0255 East Church St Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ogset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or initiury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death cate has been signed by the a page 2 should be detached to Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate funeral director, pag 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of D ath 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗍 No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be To the Hospital or Atte within 24 hours after der To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Frantioner To the best of my knowledge, death commod at the time, date and place, and due to the newself and manner stated.

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Re

strar's Signature

DIC

29c. License number

29d. Date signed (Month, Day, Year)

July 7, 2010

Please Type or Print in Black Indelibit Inde0 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Proctor Deorge June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Plata If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9/8/1944 5. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 □ F Months Washington, DC 577-56-668 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f shoi Injury or other traumatic event, Ite Madical Examinat to notified at 1 X Yes 2 No Director Waldorf Maryland Charles 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code USA 20603 Hoppy Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WSSC Skilled 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other i any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Proctor John ഉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Side Ave Swann-Shady Cerona 20746 2006 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woldert Peters 4 ☐ Donation 5 ☐ Other (Specify) 6-29-10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Theren 1589 JA 20608 23a. Part 1. Enter the disea £, or complications that caused the death. D. not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest Das Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner CVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last y physician and is the burial-trans Due to (or as a consequence of): Physician/Medical , the attending photoe defined for use as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 □ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach 23e. Did tobacco use copyribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed page 2 should been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 1 DYes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Moner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the 24 hours after death Funeral Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spącify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1. Certifying Physician: To the best of my nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

BB 6

State Registrar

DHMH 17 Rev 1/2001

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Center 7C

Post Office Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

th, Day, Year) JUN 28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death ent's Name (First, Middle Physician/ Medical , or Location of Death Examiner 1 Year If Under 24 Hrs. 8, Date of Birth Funeral Min. Months Hours /Mont/ Director Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show od. Inside City Limits 10c. City, **∦**own or Location with the Maryland Director 1 🗌 Yes 2 🖳 No 21 10f. Zip Code 10g. Citizen of What Country? Street and Number Funeral .5 21061 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status ģ Yes 2 1 NO filed within 72 hours after 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes Give Specify Specify: 5/CE(Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4, or 5+) Be Flather's Name (Fi t. Middle/Last) s Name (First, Middle, Maiden Surname ဂ္ Page 1 and 2 should ment of Health and Me Informant's Name/Relationship (Type/Print) Rurál Roi Numbe 19b. Mailing Address (Street and Number of 20b Place of Disposition (Name of cemetery, crematory of diner place) 20a. Method of Disposition 20c Location - City or Town, State Date Bunal & Cremation 3 Removal/from State 5 Other (Specify) 4 Donation any inj Signature Funeral Service Li 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-trans and Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) 4 ☐ Pregnam 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 ပ 1 DOAnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Manner of De th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending 2 No Investigation Accident completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Lettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) Name and address State JUN 2 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Funeral		5. Social Security Number 217-66-6759	6. Sex 1 ☐ M	Months Days Hours				8. Date of Bir (Month, Da	av. Year)		Country) `	ate or Foreign		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Provided Examination in the Confided and once.		20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation		oval from State			osition (Name of matory or other p		1			-		
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pital c		29a. Certifier 1 X Certifyi	na Dhuaisia	T- 4b- b4	-f len o	uniodeo dos	No. 2000 100 100 100 100 100 100 100 100 10	Alexandra de A				\I		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the aftending physi completely filled in by the funeral director, page 2 should be detached for use as the t	Medical	(Check only 2 Medical one)	Examiner:	On the basis of and manner st	of examina	ition and/or i	th occurred at the nvestigation, in m	opinion,	death occu	rred at the time	, date an	d place, and	due to the ca	use(s)
To the comp	Me	29b. Signature and title of certifie	er ~					nse numb			29d. Da	te signed (Me	onti, Day, Ye	ar)
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10		30. Name a paddress of person	who compl	eted cause of	death (Iten	i T	Print)	P	CCA	rd i	Dr.	Rach	-ville	MD
Sta Registr		31. Date filed (Month, Day, Year)	4 2011	32. Regi st	ar's Signa	ture	horred	•				<u> </u>		+
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ Month 2010 Philip Wayne June Powers Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 15 Gallorette Court Walkersville Frederick 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 12 Social Security Number 7. Age (In vrs. last hirthday) Funeral Sex 1 X M 2 □ F 217-48-9943 Director 62 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 🏋 ☐ No MD Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21793 15 Gallorette Ct United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No "natural", 3 Widowed 4 X Divorced Specify: white Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important; If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Accountant Government Contract. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence E. Powers Margie Katherine Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bette Shafer / sister 17 W. Second St., Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🏡 Cremation 3 ☐ Removal from State Smithsburg Crematory | June 19,2010 Smithsburg, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service Licensee MO1473 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the grease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Oaset and Death Immediate Cause (Final dievascular Disease Physician/ disease or condition eavs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an hasr autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

State Registrar

10

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death
Ju**Me**th 23, 1. Decedent's Name (First, Middle, Last) Florence 2010 Physician/ PERMAN Medical 4a. Facility Name (if not institution, give street and number) 1801 E. Jefferson St. #515 **Examiner** Montgomery 8. Date of Birth (Month, Day, Year) Sept. 26, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 578-18-4415 **Funeral** 1 □ M 2 🗓 F Davs Min. Months Hours Baltimore, Md Director Sept. 1919 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Funeral Director Rockville 1 Yes 2 No Md. Montgomery 10f. Zip Code 20852 10g. Citizen of What Country? 10e. Street and Numbe 1801 E. Jefferson St., #515 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married SpecifyWhite Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) B'nai Brith Secretary Be 17. Father's Name (First, Middle, Last)

Morris Weistock 18. Mother's Name (First, Middle, Maiden Surname)
Rachel Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4718 Church St., Skokie, IL. 60078 Hasha Musha Perman/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State King David Mem. Garden June 27,2010 Falls Church, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Orchinsky Hebrew Funeral Home, Inc 21. Signature of Fursiral S. 254 Carroll St. NW. Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure, List only one cau Dementia Onset and Death Immediate Cause (Final Advanced Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner tibo llation Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a conseduence on signed by the attending physician and does detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 1 🗀 Yes 🗵 🗅 9 🔲 Unknown page 2 should be detached ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by on dism 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? death? 1 Yes 2 No 24 hours after death.
Funeral Director: After this certificeted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: Certificate: To 1 Yes 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Hospital Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination allows investigation, it may opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of D69568 10 eath (Item 23a) (Type, Print) 1801 E. Jefferson St. Hirsch Center, Rockville, Md. erson who completed cause of death Atchutha Chilakamarri, MD

State

Registrar

31. Date filed (Month, Day, Year)

JUN 25 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2010 12:00 P M la Ger Trude JUNE a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year))orchester Center bridge If Under 24 Hrs Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 □ M 2 🗹 F Months Days 01 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Director bridg 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral Man 6 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 PNo Specify ģ 3 Widowed 4 □ Divorced ack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing eamstress 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be nkett ပ Mar Jackson 19b. Mailing Address (Street and Number or Tural Route Number, City or Town, State, Zip Code) 20850 19a. Informant's Name/Relationship (Type. 7.G301 Rockville, MD Mark Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 129 4 ☐ Donation 5 ☐ Other (Specify) ambridg 22. Name and Address of Ficility Henry Funera 21. Signature of Funeral Service Licenses HOME Henry Funeral". ,MD,21613 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Party Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PROSC 1891 Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 norths? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? mificant conditions of extributing to death but not resulting in the underlying cause given in Part I. 200 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ s 2 □ No 24

Physician /Medical Examiner

Funeral

Director

28a-f show

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be netitied at once.

death with the Marylar

Pages 1 and 2 should be filed within 72 hours after

permit.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours a ler death.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Physician/Medical

Completed by	Moh
Be	25. Was case ret examiner?
၉	1 Yes 2
<u> -</u>	27. Manner of De

1 Natural

29a. Certifiei

29b

Certification

Medical

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25.	Was	s case	refe	errec	l to	med	ica

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	5 Pending
	investigatio

2 Accident 6 ☐ Could not be 3 Suicide 4 THomicide

1	٣	<u>. </u>	 14	1	

28a. Date of Injury (Month, Day, Year)

and manner stated.

2. Registrar's Sign

a. Was an	2
autopsy	
_performed?	
Moes 2 □ No	
k only one)	_

26. P	lace of Death (C	Check only one)	
Other: 4	Nursing Home	5 Residence	6 ☐Other (Specia
Injury at		l. Describe how ini	

Injury at * Work?		28d. Describe how injury occurred
1 ☐ Yes	2 🗌 No	

building, etc. (Specify)	City of Town, State)		
1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place	e, and due to the cause(s) and ma	anner as stated.
2 Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion, death occu	irred at the time, date and place,	and due to the cause(s)

28f. Location (Street and Number or Rural Route Number,

Signature	and title	of certi	ifier	1	 <u>()</u>

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

29c. License number 29d. Date sighed (Month, Day, Year)

0. Name and ddi	re of person	w/ corpole	eted cause of	death (Item 23a)	(Type, Print)
	1015	11.	MAR	R D	0.

State Registrar

To the within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	1 _ State	of Marylan		rtment o tificate o				0	n 1 n	2 1	670
		1. Decedent's Name (First, Middle, Last) 2. Date of Death							<u> </u>	3. Time	of Death		
	Physicia Medic	al								2010	14	49 м	
	Examin	er	4a. Facility Name (if not institution, give street and n	umber) Indical l	Center	4b. City, Tow		n of Death SWKY	/	4c. Coun	ty of Death	omico	,
	Funeral Director		5. Social Security Number 220–12–1877 6. Sex 1 🕱 M 2 ☐ F	7. Age (In yrs. la 86	as <i>t birthd</i> ay) Yrs.	If Under 1 Ye Months De	ear If Underlys Hours	er 24 Hrs. Min.	8. Date of Birt (Month, Day 08/14/	h 1923	9. Birth Co <i>ur</i> Ma 1	olace (State itry) ylan c	or Foreign
	nd how at	5	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	ation					-	I0d. Inside (Oity Limits
	Maryla 28a-f s otified	rect	Maryland Wicomico		Eden							1 🗀 Ye	es 2 🗷 No
	with the s 23a or s	Funeral Director	10e. Street and Number 4029 Joseph Drive			10f. Zip Cod 21	de 822			10g. Citizen o		ntry?	
0000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Department of Health and Mertall Hygiene. In a proportant: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Ď	Armed	ecedent Ever in U.S Forces? es 2 \(\sum \text{No}\) Give \(\begin{array}{c}\) Dates.	If	as Decedent Yes, specify C	luban, Mexic	an, Puerto I	cify Yes or No- Rican, etc.)		ace - Americ ack, White, fy: W		
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20	iled wi Il Hygie I other vent, tl	Be	12 – 17. Father's Name (First, Middle, Last)		Contr	<u>actor</u>	18. Mot	ther's Name	e (First, Middle,			<u> </u>	
yland	uld be f Menta narked natic ev	욘	George T. Parker					······································	ret Dav				
, Mar	nd 2 shou ealth and m 27 is n		19a. Informant's Name/Relationship (Type, Print) James Joynes/nephew		4029	Josep	h Dr.,		Route Number	.822			_
lluore	Page 1 ar nent of H ant: If iter ıry or oth		20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. P	Place of Dispos emetery, crem Lisbury	sition (Name of atory or other Crema	place) tory)/2010	20c. Location Sali	n - City or To sbury		
Daltillino	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee		FSP 22.	Name and Action 100 No. 100 No	dress of Fac ay Fun ow Hil	neral 1 Rd.	Home Pr	ofessi bury,	onal A	Associ 304	lation
o p	hysician/		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on Immediate Cause (Final	each line.		r the mode of				_		Approxim Interval Bo Onset and	etween d Death
	Medical Examiner		disease or condition resulting in death) a. Due	to (or as a consequ	Colon Guence of):	nan						34 far	2 `
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	to (ur as a nonsequ	ianea cijr						- 1		
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00/0	ificate I ig phys as the		IF FEMALE:										
. DOX 001	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 124 hours after death. To the Funeral Director, Father this certificate has been signed by the attending physician and a completed filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Physician/M	23b. Was decedent pregnant 23c. If yes, of the past 12 months? 1 Li	outcome of pregna ve Birth 2 Feta regnant at time of c nknown	al death 3 🗌	Ectopic pregion Other (specification)					Date of deliv Month	ery Day	Year
S, 7.0	uires that th n signed by Ild be detac	by	Part II. Other significant conditions contributing to	o death but not res	ulting in the ur	nderlying caus	e given in Pa	ırt I.		obacco use co Yes 2 No			
vital Records,	The law requate has bee	Completed							24a. Was autop perfo	osy rmed?	prior to co death?	psy findings empletion of 2 \(\sum \) No	s available cause of
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5	ing Physi (fter this c uneral dir	ate: To	27. Manner of Death 28a. Da	Inpatient 2 Late of injury Jonth, Day, Year)	28b. Time of injury	28c. 1	njury at work?		me 5 Resid 28d. Describe h			()	
DIVISION OF	or Attend after death Director: A in by the f	Certificate:		ace of Injury - At ho ilding, etc. (Specify			1 Yes 2	-	28f. Location (S City or Tow		ber or Rura	l Route Nun	nber,
ם	Hospital 24 hours a Funeral I	Medical	29a, Certifier 1 Certifying Physician: To th (Check 2 Medical Examiner: On the	basis of examination	n and/or invest	gation, in my o	pinion, death	occurred at	the time, date a	nd place, and c	due to the ca	iuse(s) and n	nanner stated.
	To the within To the Gomple	Σ	only one) 3 Certifying Nurse Practions 29b. Signature and title of certifier	er. TO THE DEST OF M	y knowledge, d		ense numbei		e, and due to th	e cause(s) and 29d. Date sign			
	11/1/4		mu Nala				51359			June	25/5	2010	
-	22		30. Name and address of person who completed control of the completed control of the complete control of the complete control of the complete control of the complete control of the complete control of the complete control of the complete control of the control	ause of death (Item	n 23a) (Type, P ・ う 。 カ / '	rint) VISION	ST, S	SALISM	SURY, ^	10 218	04		
	Stat Registra		31. Date filed (Month, Day, Year) 32	1415 . Registrar's Signar	ture	a Ke	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June Robert J. Reynolds Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1925 1 X M 2 □ F OCt. 19, Director New York 126-18-1581 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Lanham 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6715 Terra Alta Dr. 20706 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: Specify: White 3 😾 Widowed 4 🗆 Divorced Year or Dates. '43-'63 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Restaurants Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Reynolds Rose Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David R. Reynolds / Son 6715 Terra Alta Dr., Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory 06/22/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final Physician/ Loctic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Dementia Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Yes 2 No ed by the a detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☑No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D31001 MID

State Registrar Name and address of person who

31. Date filed (Month

completed cause of death (Item 23a) (Type, Print)

MD

egistrar's Signature

ke wit

7500 Greenway Catr. Dr. #430

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-04571 State of Maryland / Department of Health and Mental Hygiene Corey Lamar Robinson 2010 21680 1- For State Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1940 hrs June 16, 2010 Medical Examiner Corey LaMar Robinson 4b. City. Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Mardela Springs Wicomico Route 50 at Wallerton Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. **S**ex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director Country) MD 9-5-1980 220-94-5985 1 X M 29 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location any 10a, State 1 Yes 2 X No s 23a or 28a-f show e notified at once. 28a-f show more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Somerset Westover rector 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 31081 Turkey Branch Road Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married 1 Yes Specify: lack 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pepsi Cola Co. Fork Lift Driver it: If item 27 is marked other other traumatic event, the M 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be traumatic event, <u>Jovce Robinson</u> <u>Oscar Wright</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 206 Walnut St, Apt 2, Pocomoke, MD 21851 <u>Joyce Robinson/Mother</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cem Robinson Family 6-26-2010 Kingston, MD Donation 5 Other Specify: 22. Name and Address of Facility 917 W. 21. Signature of Funeral Service License Isabella St. Bennie Smith 23a. Part I. Loter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Salisbury. Approximate Interval Physician Between Onset and /Medical Death a Contact Gunshot Wound of Head Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transi The law requires that the death certificate be executed sician/Medical UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the Day 3 Ectopic pregnancy 1 Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 된 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>o</u> signed t þ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has death? performed 1 🗸 Yes ✓ Yes 2 No To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical of Vital æ Hospital: 1 Other: Scene 6 V Other: Scene DOA Inpatient ER/Outpatient 3 1 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject shot self FOUND Natural Division 1 Yes 2 ✓ No Pending Director: 1940 hrs Jun 16, 2010 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide 6 Could not be Route 50 at Wallerton Road , Mardela Springs, MD within 24 hours a To the Funeral E (Specify) in vehicle on local road Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 17, 2010 rathe 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 2 | 68 | Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7 Glen Jimmy Rogers 0133 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Western MD Regional Medical Center Allegany Cumberland Social Security Numbe 7. Age (In yrs. last birthday) 66 Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Marketo, 025 year) 1944 9. Birthplace (State or Foreign Days Min. 1 🔀 📈 2 🗆 F 253-66-2000 Georgia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Great Cacapon WV Morgan 1 Yes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 25422 491 Seldom Seen Road, PO Box 368 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ ▼▼ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify: "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Plasterer 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Koontz Alton Rogers Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $P.O.\ Box\ 368$, $Great\ Cacapon$, $WV\ 25422$ Anna L. Rogers - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hagerstown Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 XX remation 3 ☐ Removal from State 7/7/2010 Hagerstown, MD 4 Donation 5 Other (Specify) Ilignature of Funeral Service Licensee Hersiey-Johnson Funeral Home, Inc. M00522 95 Union St., Berkeley Springs, W 25411-1855 23a. Part 1. Ener the disease, or complications that caused shock, or heart failure. List only one cause on an h line disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ neumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ☐ Live Birth 2 ☐ Fetal death ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No Day Month Year sate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 110 After this certificate 1 Yes 2 No Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print on Dr Chmberland M

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State Registrar 70Mg

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Physician /Medical	1. Decedent's Name (First, Mic Gloria E	, ,						2. Date Mon Ju
Examiner	4a. Facility Name (If not instituted Bel Air Hea.		,	er	4b. City, To Bel 2		Location of Death	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)		Year Days	If Under 24 Hrs. Hours Min.	8. Date

85

Vrs

215-12-9085

Usual Residence of Decedent

1518 Main St.

1 Never Married 2 Married

3 □ Widowed 4 □ Divorced

10b. County

Harford

C. Jones

10a. State

MD

11 Marital Status

David

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

10e. Street and Number

Director

28a-f show

death v

within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Certification:

Medical

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permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, Italiance.

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of Death 3. Time of Death ^{Day} 2010 3 12:25P M . У

4c. County of Death

USA

Reg. No.

Harford ate of Birth Jonth, Day, Year) 10/1925 Birthplace (State or Foreign Country) Months Davs Hours Min Maryland

10c. City, Town or Location 10d. Inside City Limits 1 Xes 2 No Whiteford

10f. Zip Code 10g. Citizen of What Country?

21160 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 → No Specify

Black White etc. ^{Spe}White

14. Race - American Indian,

Approximate Interval Between Onset and Death

1 □Yes XXNo If Yes, Give Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 health

<u>practical nurse</u> 17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname) Charlotte J. Henry

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)

David G. Williams Sr -1702 Whiteford Rd., Darlington, MD 21034 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State

Slate Ridge Cemetery 7/7/10 Delta, PA 17314 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licely 22. Name and Address of Facility

Muson Harkins F.H.Inc., Delta, PA 17314

23a, Part 1. Enter the disease. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

3 Ectopic pregnancy 5 ☐ Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Month

23d. Date of delivery

Day

Year

24a. Was an autopsy performe

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 XNo 1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

2010

July 6,

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4XXIursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation

1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

M.D. D56545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cenera

Dr. Shilpi Khosla, 615 W. McPhail Rd., Suite 106, Bel Air, MD 21014

29c. License number

32. Registratr's Signature

31. Date filed (Month, Day, Year) State JUL 122010 > Registrar

29b. Signature and title of certifier

P.O. Box 68760, of Vital Records,

The law requires that the death certificate be executed Attending Physician: Division Hospital or

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10 21683

steven Negron	,	1-For State Of Maryland / Department of Health and Mentar High	_	eg. No.	
Physici		Decedent's Name (First, Middle,Last)	Date of Deat Month	th Day Year	3. Time of Death
Medical Exam	iner	beeven negron	June 28, 2	2010	1325 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
		400 E. Walnut Street Hebron		Wicomico	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.		th(MM/DD/YYYY) 9. Bir Foreig	
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any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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Maryland 28a-f show 1 at once.	tor	MD Wicomico Hebron 10e. Street and Number 10f. Zip Code	140	og. Citizen of What Cour	
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21215-0036 suld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, N	Maiden Surname)	
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. Tant: If item 27 is marked other than " or other traumatic event, the Medical.		Maribel Rolon-Semprit/ mother 400 E. Walnut Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	- Hebro	On, Marylan 20c. Location - City or	
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Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr	(2) Signature of Funeral Service Licensee 22. Name and Address of Facility Jolley Memorial Ch.	Salisbu:	ry, Marylan	d Dood 21901
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/Medical		failure. List only one cause on each line.			Between Onset and Death
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	ner	if any, leading to immediate Due to (or as a consequence of):			
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68 certifi ding	ia	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Out (Pageital)	ncy	Month D	ay Year
Box 687 e death certific the attending p	Fhysician/	1 Yes 2 No 9 Unknown 9 Unknown			:
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	o Be	examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other, Nursing		Residence 6 🗸 Other	Scene
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Dital o	Certification:	4 Homicide determined (Specify) found at home	Hebron,	rateMD 22	
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be execut d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detacled for use as the burial - transit		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and			
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	Σ	29b. Signature and title of certifier 29c. License number		29d, Date signed (Mor	th, Day, Year)
		Pat a - Poller O.C.M.E.		June 29, 2010	
		30. Name and address of person who completed cause of death (Item 23a) Potricio Arcoico Pollo MD Accistant Modical Evaminor 111 Ponn Street Baltimore	MD 24204		
	لي	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore	s, IVID 21201		
Sí Regis	ate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 10:34 PM Year Month **Physician** RUSSELLO MICHAEL 06 2010 OSEPH DJ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** DORCHESTER CAMBRIDGE 1136 HUDSON Date of Birth (Month, Day, Year) 1/12/1915 9. Birthplace (State or Foreign if Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Social Security Number NEW YORK **Funeral** Min. Months Days Hours 1 № M 2 🗆 F 95 Yrs. 053-03-6345 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eval. And Indical Eval. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No CAMBRIDGE Director MARYLAND DORCHESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21613 1136 HUDSON RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mays 2 D No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. WHITE à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OIL TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET PEPE PASQUEL RUSSELLO ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1136 HUDSON RD., CAMBRIDGE, MD 21613 CAROL GRIFFITH / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CAMBRIDGE, MD 7/10/2010 GREENLAWN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Fun-CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death Year Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Dilinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 PNo Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Iniury 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide

Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director; After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact.

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 69234 2010 0 1 N

STREET

MO

CAMBRIDGE,

-21613.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERRABOLU PID, 503 JEEVAN

32. Registrar's Signature 31. Date filed (Month, Day, Year)

10

State Registrar

29a, Certifier

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		`.	For State Registrar		State of Ma	iryianu / L		tificate of i	Death		Reg. No.	010	21685	
	Physicia	an	1. Decedent's Name (Fi							2. Date of Dea	ath Day	2 Year	3. Time of Death	
	/Medic Examin	al	Donald Kir 4a. Facility Name (If not	ng Smith t institution, give st	reet and number)		Т	4b. City, Town, or	Location of Death	Jurie	4c. (County of Dea	ath	-
and the same			Civista	Medico	1 Cente	25		Laf	Plata	o Data of Div	41-	Char	rthplace (State or Foreign	
	Funeral Director		5. Social Security Numb) 1 X D	M 2□F	81	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11/13/	1928	C	irginia Lrginia	,
	land ow		Usual Residence of Dec 10a. State 10t	b. County		10c. City, Towr	n or Loc	ation					10d. Inside City Limits	
	e Mary ka-fsh Liftert	ctor	MD C1	harles		White	Pla:	ins					12∏Yes 2□No	
	ith the	Dire	10e. Street and Number					10f. Zip Code			10g. Citiz	zen of What C	ountry?	
	eath v	Funeral Director	10032 Rhode		2. Was Decedent B	Ever in U.S.	13. W	20695 /as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No			erican Indian,	_
036	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, I'm Mcdenl Francing must be notified at	by	1 □ Never Married 3 🖾 Widowed 4 □		Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	an, Mexican, Puerto Specify:	Rican, etc.)		Black, Whi	white				
2-003p	72 hou dien L	eted	15. (Specify o	Decedent's Educa	ation completed)	Army 16a.	. Decede	ent's Usual Occup	oation during most of work d)	ing	16b. Kir	nd of Business	s/Industry	
7	filed within Hygiene. wther than "	Completed	Elementary/Secondar	ry (0-12)	College (1-4or 5	+) A		ONOT use retired itect	d)		Fed	eral G	overnment	
ם ס	e filed val Hygie other i	Be Co	17. Father's Name (Firs	st, Middle, Last)					18. Mother's Nam	e (First, Middle	, Maiden S	Surname)		
yland		TO E	Reddingto	n Smith					Mary Gre					
, Mar	nd 2 shu alth and 27 is m r traum		19a. Informant's Name. Ronald A.			19b	o. Mailing	g Address (Street Rhodes D	and Number or Rui r. White	Plains,	MD	20695		
ore,	Pages 1 ar nent of Hez int; If item iry or othe		20a. Method of Disposit		moval from State			ition (Name of atory or other plac		Date		•	r Town, State	
Бащтог	t. Pa rtmer rtant		4 □ Donation 5 □ 21. Signature of Fullera	Other (Specify)	-	Trini		Memorial Name and Addre	Gard. 6/				aryland	_
g	Depa Impo any is		21. Signature of Panera	Rival	- Moi	190			Hu ashingtor	ntt Fur Rd. Wa	neral ildor	Home f, MD	20601	
			23a. Part 1. Enter the d shock, or heart fa	disease, or complications. List only	ations that caused cause on each lin	the death. Do	not ente	r the mode of dyi	ng, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death	
Sec.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	al a.	Cons	UNIL	H	east t	allile				years.	_
	Examiner	П		ſ.	Due to ras	na consequence	01): H-H	my Du	alue				year.	
-	p ti	iner	sequentially list condition if any, leading to immediate. Enter Underlyin Cause (Disease or injudance)	diate ng	Due to (or as	a consequence	of):	1					means	
	tificate be executed by physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	C.	Due to (or as	a consequence	of):	11					Jest of	-
09/89	ate be hysicia he buri	edical		d.										
	certifica ding pl		IF FEMALE:	29	sc. If yes, outcome	of pregnancy						22d Data of a	Inlivery	
O. Box	isian: The law requires that the death cert certificate has been signed by the attendin rector, page 2 should be detached for use	Physician/N	23b. Was decedent pre in the past 12 mor 1 □ Yes 2 □ No 9 □ Unknown	nths?	1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death		Ectopic pregnand Other (specify) _	су			23d. Date of c Month	Day Year	
7.	requires that the neen signed by th	by Ph	Part II. Other significat	nt conditions conf	ributing to death b	ut not resulting i	n the un	derlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute	to the cause of death?	
ğ	equire en sig buld b	ted b		Renai	, aucr					1 🗆	Yes 2[_No 3□	Probably 4 Unknow	n
I Kecords,	The law re ate has be bage 2 sho	Completed								24a. Was auto perfo 1 □ Yes	psy ormed?	prior t	autopsy findings available o completion of cause of ? es 2 □No	е
VItal	ician; certific ector,	Be	25. Was case referred examiner?	<u> </u>	ospital:			Tott	26. Place of Dea	,				
0	Physi r this c ral dir	1:10	1 Yes 2 No 27. Manner of Death	113	28a. Date of Inju (Month, Da	ent 2 ☐ ER/O iry 28b.	Time of	28c. Inju	ry at	ome 5 ☐ Res 28d. Describe			pecify)	_
<u>0</u>	nding ath. r; Afte e fune	atior		Pending investigation	(Month, Da	y, Year)	Injury	M 1 🗆	rk?]Yes 2 □ No					
DIVISION	I or Atte after dez Directo	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of Inj building, et	ury - At home, fac. (Specify)	arm, stre	eet, factory, office		28f. Location City or To	(Street an wn, State	d Number or)	Rural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificy completely filled in by the funeral director,	ledical C	29a. Certifier 1 (Check only 2 one) 2	Certifying Phys					ime, date and place opinion, death occu					
	To the within To the compl	Me	29b. Signature/arto/title	y of certifier	Im.			29c. Licen	se number	9	29d. Da	tersigned (Mo	onth, Day, Year)	
	20 41	,	30. N me address	of person who co	mpleted cause of c	leath (Item 23a)	(Type, I	Print)	se number) 46 4 19		- /	1410 =	-	
ľ	DOCK	1	Charlene 31. Date filed (Month, I	Letch-	32. Registr	ar's Signature	Tar	rett /	venue	la Ma	ta,	MD 2	0646	
	Sta Registr			N 2 5 201	O Die	w B.	ba	ale						

DONALD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ 2010 George Savoy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Char Plat If Under 1 Year If Under Social Security Number Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign Birthpic Country) Md **Funeral** Hours (Month, Day, 7 / 3 0 / ^{Year)} 1946 Director 219-42-3557 63 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ural", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Indian Head Charles Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 110 Bertha Circle 20640 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married laryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4 X Divorced Black Completed permit, Page 1 and 2 should be filed within 72 hour Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) College (1-4 or 5+) 5 + Elementary/Seconday (0-12) Civil Engineer Federal Government 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) С. Savoy Sr. Cordelia Ε. Branson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Bertha Circle, Indian Head, Margaret Seward/Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/30/2010 La Plata, Md. Sacred Heart Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bluford Funeral Service 21. Signature of Funeral Service Licensee 2019 Martin Luther King Ave, Wash. DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ·Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown this certificate has been signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Division of Vital Records, P.O. Box 68760

Completed by Be မ Certificate:

24a. Was an Were autopsy findings available prior to completion of cause of autopsy death?

25. Was case referred to medical examiner? 2 No 1 🗆 Y9/s 27. Manner of Death

VNatural

Sig

Accident

Hospital 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 5 Pending Investigation

ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,

City or Town, State)

1 Yes

3 Suicide 4 Homicide determined Certifier (Check

6 Gould not be

ess of person who completed

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or in

3 Certifying Number Practioner: To the Best of my knowled ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number

cause of death (Item

igned (Month Day, Year)

0

State

Medical

ON

iniury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funer.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18ay Jumer 201°0° 17:14 Harold Clair Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1**y** M 2 □ F Days Hours Months 0971271920 89 Pennsylvania Director 174-16-8875 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Directo **Annapolis** Maryland Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 229 Riverside Drive 21409 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 | No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1943-46 Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Technical Publications Manager Defense Contractor 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Oliver C. Smith Ethel B. Kunes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 229 Riverside Drive, Annapolis, Maryland 21409 permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other tra Lorraine A. Smith/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State 06/21/2010 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dee within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3. Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date sighed (Month, Pay, Year) 29b. Signatu cause of death (Item 23a) (Type

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			State of Maryland / D					01600			
			- State Registrar	Certificate of De	eath		1. N2 0 1 0	21688			
	Physicia	an	1. Decedent's Name (First, Middle, Last)			June June	eath 3. Time of Death 15 2010 8:42 P M				
	/Medic	al	Jeremiah W. Swann 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo		o une	4c. County of Death				
	Examin	er	1983 West St. Rear	Annapo			Anne Ar				
Т	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year Months Days		r 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign					
	Director		214-10-0020	Yrs.	J	une 17	1919 Mar	yland			
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		-		10d. Inside City Limits			
:	Mary P-f sh	ż	Maryland Anne Arundel Anna	polis				1 ☐ Yes 2 💢 No			
	or 28g)irec	10e. Street and Number .	10f. Zip Code		100	g. Citizen of What Cou	intry?			
	s 23a	Funeral Directo	1983 West St. Rear	2140			USA	to disconnection			
	items	-in-	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never 2 No	13. Was Decedent of Hisp If Yes, specify Cuban,	oanic Origin? (Spe Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White				
2-003p	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If tiern 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Evaniment use the routified at once.	ρ	3 Widowed 4 Divorced If Yes, Give 1943-45	1 ☐ Yes 2X No	Specify:		Specify: B1	ack			
-c	72 ho 'natur	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupati (Give kind of work done dur			Sb. Kind of Business/I Jnited St				
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yland	lid be fental rked c	To Be	Jeremiah S. Swann		Edna H.	Washir	ngton				
Mary	shou and N s mai		19a. Informant's Name/Relationship (Type. Print)	. Mailing Address (Street an	nd Number or Rura	al Route Number, (City or Town, State, Z	ip Code)			
e` `e	and 2 lealth m 27 i	3		983 West St			olis, Md.				
9	iges 1 nt of H : If ite or ot		1 LX Burial 2 Li Cremation 3 Li Removal from State	Disposition (Name of ry, crematory or other place) rial Park	6-22		oc. Location - City or 1 Annapolis				
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o O	permit Depar Impor any In		Jane H. Ace and 483	821 West			_				
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying,	, such as cardiac o	or respiratory arres	st,	Approximate Interval Between			
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×	ding p	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of del	iverv			
ž č	atter 1 for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Ves 2 ☐ No 25c. Sociotima to positive birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year			
5	t the c by the	hysi	9 Unknown								
ς, S	es tha igned be del	by P	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given	in Part I.		acco use contribute to				
Hecords	requir een s nould	ted				1 🗆 Yes	3	obably 4 Unknown			
Ģ.	e law has t je 2 sl	Completed				24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of			
VITAI :	n: Th ificate or, pag		25. Was case referred to medical		OC Plans of Doot	1 ☐ Yes 2, n (Check only one)	No 1 □Yes	2 🗆 No			
>	ysicia is cert directe	To Be	examiner? Hospital:	utpatient 3 DOA Other			nce 6 ☐ Other (Spe	cify)			
ם י	ng Ph fter thi	T:U	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b.	Time of 28c. Injury a	at	28d. Describe hov	w injury occurred				
Sio :	tendii eath. Ior: A the fu	catic	2 Accident investigation		es 2□No	201		- Court Municipal			
DIVISION	or At after d Direct in by	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	irm, street, factory, office		City or Town,	eet and Number or Ru State)	arai Houte Number,			
- V.	To the Hospital or Attending Physician: The law requires that the death certnit within 24 hours after death. Within 24 hours after death. To the Furnarial Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	ledical Co	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination at and manner stated.								
:	To the within To the comple	Мес	29b. Signature and title of certifier	29c. License	number	29	d. Date signed (Mont	h, Day, Year)			
		1	> 4. Jeloulles as		4838		6/16/2	-010			
	6 W		30. Name and address of person who completed cause of death (Item 23a) STUAVE E. SCIONICK, MO	(Type Print) Bestga	te Rd.	Annap	6/16/2 00/1s, Md	. 21401			

State Registrar

DHMH 17 Rev 1/2001

		For		St	ate of	Marylan	nd / Depa	ırtment of H	lealth	and M	1ental Hy	giene	9			
		= State Registrar					Cer	tificate of L	Death		-	Reg. No	20	0	21	689
Physicia	n/	1. Decedent's Name									2. Date of De Month	_	ay - '	Year	3. Time	
Medic		Louise F		hellin							June	13		61°0	3:35	РМ
Examine	er	4a. Facility Name (if r						4b. City, Town, or Odent.		of Death			:. County o		_{[മ}	
Euroral		HeartHome 5. Social Security Nu		6. Sex		Age (In yrs. I	ast birthday)	If Under 1 Year	-	er 24 Hrs.	8. Date of Bir	rth	100		lana (Ctata	or Foreign
Funeral Director		224-26-49		1 □ M 2		86		Months Days	Hours	Min.	(Month, Da Dec. 3	av. Year)	23	Count	Viro	rinia
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yland -f shc ed at	향	10a. State MD	10b. County	Arunde	1		ty, Town or Loc Crofton							10		City Limits
e Mar r 28a- notifi	Director	10e. Street and Num				`		10f. Zip Code				10 0	''' 5 \A/I			es 2 💢 No
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ursaf ural" al Exa	ted	3 Widowed 4		Ye	Yes, Give ar or Date	s.		1 ☐ Yes 2 💢 No Specify:						Whi	te	
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iled w I Hyg othe /ent,		17. Father's Name (F	irst, Middle,	Last)			1 . 11100	CLOTILOD			e (First, Middle	, Maiden				
2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at	욘	David Wil	lliams						Ed:	ith W	loods					
should and h is ma		19a. Informant's Nar			,			g Address (Street						te, Zip C	ode)	
and 2 Health tem 27		Brenda Wa		Daught	er			Harrow A	ve.,							
ge 1 and the street of the str		20a. Method of Dispo 1 X Burial 2	Cremation	3 🗌 Remo	val from St	ate	cemetery, crem	sition (Name of natory or other plac	ce)		Date		ocation - C	_		D
permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		4 Donation 21. Signature of Fun				Lai		Mem'l Pa			4/2010	<u> </u>	ridsor		.е, M	
permit. Departn Imports any inju once.				LICCINGCO	-0	\sim		Name and Address								
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Physician/		Immediate Cause (F	inal	only one caus	se on cach	Str	oke								nset and	
Medical Examiner		resulting in death)		a. —	Due to (or	as a conseq	/ /	mell	1, 4.	,	_	-			10110	
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be executed sician and burial-transit	Еха	that initiated events resulting in death) L		С. —	Due to (or	as a conseq	uence of):									
or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the aftending physician and in by the funeral director, page 2 should be detached for use as the burial-transin by the funeral director.	edical			L d												
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requires that the de been signed by the should be detached	y Ph	Part II. Other signific	cant conditi	ons contribut	ing to dea	th but not res	sulting in the u	nderlying cause gi	ven in Par	rt I.	23e. Did	tobacco	use contrib	oute to th	e cause of	death?
uires t n sign ald be	q pe										1 🗆	Yes 2	140	3 🗌 Prob	ably 4	Unknown
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ysician: is certific director,	Be (25. Was case referre examiner?	-	Hospita	al·		_			eath (Chec	k only one)				Astes	ted
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ding th. After funer	cate	1 Accident	5 🗌 Pendi			Day, Year)	injury	worl	ya: ⟨? Yes 2[260. Describe	now inju	ry occurred	4		
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talor ins afte al Dir led in					bullaring	, etc. (Specif	y) 				City or To	wn, State	=)			
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2	Medical i	Examiner: Or	the basis	of examinatio	on and/or invest	occured at the time igation, in my opinion	on, death	occurred a	t the time, date	and place	e, and due	to the cau	use(s) and r	manner stated.
o the vithin to the comple	Σ	only one) 3 29b. Signature and t			fioner: 10	the best of m	iy knowledge, d	death occurred at the 29c. Licens			se, and due to t		ate signed			
		> 9ll	let	M	rat	3		12	0074	1		0	6/2	2/10)	
		30. Name and addre	ss of person	who complet	ted cause	of death (Iten	n 23a) (Type, P	Print)	0	v n	2 2	11	/ h	10:		. ~
HO		5) Lotte filed (Month	JOI	6 9ty	MY	istrar's Signa	1 N	adun	rur	L, Vi	rive,	ore	u D	IIni	" My	12/00/
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21690 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Dore Sharf 2010 9:05 Medical Tune 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 61 Director 088-40-7934 1948 Virginia 4 West Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified. 1 Yes 2X No Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20882 8324 Hawkins Creamery Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married 1 Yes 2 No Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Automotive Tech. Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Shirley Cohen Chester Milton Sharf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronnie Sharf/Spouse Hawkins Creamery Road, Gaithersburg, MD 20882 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State Ft. Lincoln Crematory 6/28/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M01463 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate (Juse (Final disease or c indition resulting in death) Colon Metastatic Physician years Medical Due to (or as a consequence of) Examiner Sequentially list nor ditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

(a the Funeral Director; After this certificate has been signed by the attending physician and is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day 1 Yes 2 9 Unknown 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 № No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) npleted filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 23 29d. Date signed (Month, Day, Year) Goseph M. Hagzerty MO 32407 2010 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jos<u>eph Haggerty</u>, 9707 Medical Center Dr. Suite 300 Rockville, MD 20850 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HOPE PHYLLIS DICKINSON SHIRES June 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. (Month, Day, Year) Director 87 Benton 337-16-9901 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e, Street and Number 10f, Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 156 Fleetwood Terrace 20910 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 👿 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Domestic 4 Years Homemaker Be permit. Page 1 and 2 should be filed i Department of Health and Mental Hyy Important; If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Dickinson Maude Isabell Flotho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 156 Fleetwood Terrace, Silver Spring, MD 20910 <u> Virginia S. Marcum/Daughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State East Tennessee State 06/307 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Knoxville, Tennessee 4 Donation 5 Other (Specify) Veterans Cemetery 2010 Signature of Funeral Service Licenses No #1070 22. Name and Address of Facility HINES-RINALDI FUNEAL HOME, INC. 11800 New Hampshire Ave. Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypercarbia Respiratory Failure Medical resulting in death) Due to (or as a consequence of) Examiner Emphysema Sequentially list conditions Examine if any leading to immedicause. Enter Underlying Due to (or as a consequence of): physician and sthe burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed Bronchiectasis that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown signed by the sid be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Renal Failure 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has funeral director, page 2 autopsy performed this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 X Natural 5 Pending death. Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the F only one 29b. Signature and title of certifier 29c. License number 2 29d, Date signed (Month, Day, Year) The D0064100 06/22/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 Smitha Bhikkaji, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

JUN 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CYNTHIAL SMITH 2010 2100 JULE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CENTER UNIV. OF MACYLAND BALTIMORE MEDICAL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) New York 1 🗆 M 2 🕱 F Days Hours Min 1949 Director 213-50-7915 61 June 13, Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 520 Lawson Way 20850 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working College (1-4 or 5+) Montgomery County Public Schools Elementary/Seconday (0-12) Special Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ments Important. If item 27 is marked any injury or other traumatic e John W. Smith, Sr. Eleanor Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Smith/Brother 301 Timber Ridge Road, Marysville, PA 17053 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20c. Location - City or Town, State June 28 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 MO1503 23a. Part 1 Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest such, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Arrhythmia Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Physician/Medical Examine Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fulminant hepatic failure ; kidney failure; septic shock 1 Yes 2 No 3 Probably 4 MInknown within 24 hours after death.

To the Funeral Director: After this certificate has been significated filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

State Registrar

DHMH 17 Rev 7/2009

29a. Certifier

ANDREA 31. Date filed (Month, Day, Year) M.O.

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JUN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 5.

Registrar's Signature

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Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

#919

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

June, 23, 2010

BALTIMORE, MD 21201

29c. License number 124355

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Mildred Colombo Sutter 2010 22 9:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Raphael House If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 085-16-1692 1 M 2 T F Min. Hours 0991671914 New York Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Bethesda 1 🖁 Yes 2 🗆 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20816 5406 Cromwell Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1 Yes 2 XNo Specify: Specify: Completed 3 √2 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mediconce. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Service Coordinator Blue Cross/ Blue Elementary/Seconday (0-12) College (1-4 or 5+) Shield Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Louise Vaccaro Paul Colombo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5406 Cromwell Dr. Bethesda, MD 20816 Susan Helm / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ▼ Burial 2 ☐ Cremation 3 ▼ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 6/28/10 Eastchester, New York Holy Mount Cemetery 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funera Sirvige Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease for complications that carlsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eagh line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani Renal disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): oren ary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner attending physician and for use as the bunal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day ate has been signed by the a page 2 should be detached it g 🔲 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIabetts 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an Advanced autopsy within 24 hours after death.

To the Funeral Director: After this certificate 2 🗆 No funeral director, Be 25. Was case referred to medical Assisted 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 V Other (Spe Living မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 34 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Timen CRNP R172412 Mysm 6/24/2010.

State Registrar

31. Date filed (Month, Day, Year) 2. Registrar's Signature JUN 2 5 2010

Alyson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1801 E. Jeffelson St. RO(KVIIIC, MO 20852 2. Registrar's Signature

State Registrar

30, Name and address of person who completed cause of least them 23a) (Type, Print) 830 CHESAVERLE DOINE, CAMBRIDE, MARKAND 21613 37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. ZU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CHARLES L. SCHER 6/21/2010 2:59 P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death DORCHESTER GENERAL HOSPITAL **CAMBRIDGE DORCHESTER** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 1**X** M 2□ F Months 219-46-4317 62 3/15/1948 **NEW YORK** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No MARYLAND **DORCHESTER CAMBRIDGE** 10f. Zip Code 10g. Citizen of What Country? 1006 LOCUST STREET 21613 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2XX No Specify. WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) TENNIS PROFESSIONAL ATHLETIC 18. Mother's Name (First, Middle, Maiden Surname) MURRAY V. SCHER BELLE KABOT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 E. 62ND ST., APT. 6-K, NEW YORK, NY 10065 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date CEDAR PARK CEMETERY 7/1/2010 EMERSON, NJ

permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trau **Physician** /Medical

Examiner

Physician

/Medical

10a, State

Examiner

Funeral

Director

28a-f shov

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or Items 23a

"natural"

is marked other than

1 and 2 should be fi Health and Mental I

Pages 1

death certificate be executed

Box 68760.

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Records,

of Vital

Division

Injury or other traumatic event, the Medical Examiner numbe notified at

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death 24 hours a

within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	
within 24 hours a	To the Funeral L	completely filled	

Directo 10e. Street and Number Funeral 11. Marital Status 1X Never Married 2 ☐ Married þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) MARILYN SCHER / SISTER 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sep-22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause o each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💓 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 2 \square No 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pes 2 □ No 2 R/Outpatient 3 DOA 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. ess of person who completed cause of death (Item 23a) (Type, Print) Centre Blud, Annapolis Mayland 2144

State

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death ^{Day}2010 Physician/ June 11:40 P M 20 Anthony Thomas Scoglio Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 3511A Oak Drive Edgewater Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months 1 X M 2 □ F Days Min. 3711771949 216-50-9083 61 Washington, DC Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2 🖰 No or 28a-f Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3511A Oak Drive 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Minister Religion years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Romulus Scoglio Dorothy Louise Lunsford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Scoglio/ Wife 3511A Oak Drive, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion U.M. Church : 6/25/10 Lothian, Maryland 21. Signature of the service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. r art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final UPUT S Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year Pregnant at time of death signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 To the Hospital or Attending Physician: • within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending work 1 Tyes 2 No Investigation Could not be ☐ Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Mont), Day, Year)

State Registrar

P.O. Box 68760

Records,

Division of Vital

445 Defense Hwy., Annapolis, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

egistrar's Signature

Susan H. Krieger

31. Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend #8 Per FH G907 9/29/10 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:49 A M Physician/ Sune Sune GRE99 RUNC 2010 Liam Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 1205 AVALONBOYLEVARD ANNE ARUNGEL 8. Date of Birth 1/26/1941 Birthplace (State or Foreign (Month, Day, Part) NY 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1**XX**M 2 □ F Min. Director 123-30-1667 69 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c, City, Town or Location Director MD Shady Side 1 Yes XX No Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1205 Avalon Blvd. 20764 IISA hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hyghen. Important: If item 27 is anaked other than "natural", or i any injury or other traumatic event, the Medical Examin any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: 3 Widowed 4xxDivorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Wood Worker 0wner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William D. Strunck Louise Erni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9790 June Flowers Way Laurel, MD 20723 Cari Penniman Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 6/25/2010 | Crownsville, MD Signature of Funeral Selvice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner obracher pulmona TOS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Division of Vital Records, P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ lymphocytic Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an las performed? certificate 1 ☐ Yes 2 ☐ No 1 Dires 2 No in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined completed filled Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 North Greene Street Raltimore, MD 202 d cother D Wanned 11/12 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7,8 per 1h 9905 7-29-10 vt State of Maryland / Department of Health and Mental Hygiene 2010 21698 State Registrar Certificate of Death Reg. No. nt's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 5707 East Place Forestville Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Pay, Ye Jan 5, 1 1932 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🖾 F Director Yrs. Jan. 250-58-5689 78 SC Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2 🏝 No MD Prince Georges Forestville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5707 East Place 20747 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) 8th College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lawrence Gowdy Elzada McKie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Samuels - Husband 5707 East Place Forestville, MD. 20747 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 6-24-2010 Cheltenham, MD 21. Signature of Funeral Service Licensee Marshall's Funeral Home of Maryland larine 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No ģ Day Month Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tor; After this certificate has the funeral director, page 2 at performed 2 🗓 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 X Natural 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gentifying Number: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Number: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) M D53885 6/18/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

P.O. Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

Venhat S. Ramanan

31. Date filed (Month, Day, Year) **JUN 2 9 2010**

#307

Clinton, MD. 20735

7501 Surratts Rd.

32. Registra is Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Abraham David	Sei	1- For State Registrar	tate of Maryla		artment o ertificate o		nd Men	tal Hy	_	eg. No.	201	0	21	699
Physic Medical Exam		1. Decedent's Name (First, Midd		-i+		_			2. Date of Dea Month	Day	Year	1	Time of D	
vicuicai Exam	IIICI	Abraham Da 4a. Facility Name (if not instituti				4b. City, Town, o	or Location o	of Death	June 28, 2		ounty of D		1323 111	3
		400 E. Walnut Street				Hebron	Wicomico							
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye		r 24Hrs.	8. Date of Bir	rth(MM/DD		roign		
Director	i	596-50-6604	1XM 2_F	16) Yrs	Months Da	lys Hours	Min.	12/29	9/1993	3	Countr	y) Pue	rto Ri
any		Usual Residence of Decedent 10a, State 10b. County		10c City	, Town or Locat	ion						110	d Incido (City Limits
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Baltimore, permit. Pages I ar Department of Hea Important: If iter injury or other tr	- A	21. Signature of Funeral Service	Licensee			lame and Addres			Salisbu	ry, M	aryla	ind	ond '	21901
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Box 6876 e death certificate the attending phy	cial	past 12 months?	4 Pregna	irtn ant at time of de	ath -	tal death 3 ner (Specify)	Ectopic	pregnar	icy	Mo	πtn	Day		Year
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical Ce		hysiclan: To the best miner:On the basis o	t of my knowled of examination a	ge, death occurr	red at the time, d		ce, and c	lue to the cause	e(s) and ma	anner as s	stated.		
F. 25 8	Me	29h Signature and title of certifie	and manner sta	alcu.		29c. Licens	se number			29d. Date	signed (i	Month,	Day, Year)	
		Total lin	- You	lle.	_	O.C.	M.E.			June 2	9, 2010			
	1	30. Name and address of person Patricia Aronica-Pollal		e of death (Item int Medical I		111 Penn S	treet Rai	timoro	MD 21201					
	ate	31. Date filed (Month, Day, Year)		gistra s Signatu		- Felli S	ucel, Dal	uniore	., IVID 21201					
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lucille Mildred 29^{ay} Souder June 2010 2:40P. Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12021 Old Gunpowder Road Prince George's Beltsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min Feb. 16, 1935 579-48-6719 75 MaryTand Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if fine 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Martinal Exercise. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Delaware Ocean View Sussex 1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1 Palisade Street 19970 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Lawrence Ford Letitia B. Yowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen L. Spicknall -daughter 12021 Old Gunpowder Road Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Fort Lincoln Cemetery 7/6/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licer Bonald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Vears Immediate Cause (Final Physician/ Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 24 No Month Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy death? 2 🗓 No 1 Tyes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မှု 1 Tyes 2 🖾 No Other: 4 Nursing Home 5 Residence 6 Nother daughter's home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA eral Director: After this filled in by the funeral di 27. Manner of Death 1 XNatural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a Medical 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D38560 June 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nicholas Koutrelakos, M.D. 10710 Charter Drive, #G020 Columbia, Maryland 21044

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1617 Jennie Sheeler Taylor Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional medical WICOMICO Conto 3115bun 5. Social Security Number 9. Birthplace (State or Foreign Country) 8 Date of Birth Funeral 7. Age (In yrs. last birthday) If Under 24 1 □ M 2 🔀 F Months Days Hours Min. 220-25-1696 Director 90 PA Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
It marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Snow Hill 1 Yes 2 No Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5517 Taylor Rd. USA 21863 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 No Specify: Specify: Completed 3X Widowed 4 ☐ Divorced white Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Food Service Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Paul Sheeler Katie Good 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Taylor 5506 Taylor Rd., Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 6/26/2010 Bates Cemetery Snow Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or). Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2 No Yes 2 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) o 24 hours after death.

Funeral Director: After the leted filled in by the funeral 27. Mann f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date signed (Month, Day, Year)

Registrar

State

BA2

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010

ampson Georg	je V	,	epartment of Certificate of		d Mental	Hygiene	20	10 21/02				
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	Jeruncate or	Deam		2. Date of Dea	Reg. No.	3. Time of Death				
ledical Exami		Sampson George Vince	ent			Month June 25,	Day Year	1250 hrs				
		Facility Name (if not institution, give street and number) Peninsula Regional Medical Center		4b. City, Town, or Salisbury	Location of D	eath	4c. County of Wicomico					
Funeral	г	5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Yea			irth(MM/DD/YYYY)	9. Birthplace (State or				
Director		220-68-9400 1XM 2 F 53	2 Yrs	Months Day	s Hours	Min. 10/08	3/1957	Foreign cod Maryland				
ž.		Usual Residence of Decedent 10a. State 10b. County 10c. (City, Town or Locati	00				10d. Inside City Limits				
1 iow any		Maryland Wicomico Calichum										
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th the Maryland 23a or 28a-f sho notified at once.	Dire	3686 Devonshire Drive		2180	4		USA					
h with	uneral	11. Marital Status 12. Was Decedent Ever in Armed Forces?		s Decedent of His es, specify Cubar		(Specify Yes or No		American Indian, Black,				
or deat	Fun	1 Yes 2 X N				iono moun, oto.,		white				
urs afte tural" mainer	l by	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	d) 16a. Deceden	Yes 2 X No		of work done	Specify: 16b. Kind of Busi					
72 hou n "nat	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	during me	ost of working life	. DO NOT use	e retired)		,				
yithin ene er tha	Completed	12 5+	atto				law					
21215-0036 Und be filed within 72 hours after death with Mental Hygiene. marked other than "natural", or items cevent, the Medical Examiner must be	ပိ	17. Father's Name (First, Middle, Last) Carl Elmer Vincent Sr.				lame (First, Middle, a Mae Per	,					
212 ould be I Ment mark ic even	To B	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Stree			mber, City or Town,	State, Zip Code)				
MD td 2 sho tlth and m 27 is aumati		Jill M. Vincent spouse					bury, MD					
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mendal Hygiewie. The file of Health and Mendal Hygiewie was "nearural", or items 23a or 28a-f she mit. If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	Ob. Place of Disposi crematory or oth		netery,	Date	20c. Location - (City or Town, State				
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Baltimore, MD 21215-0036 pentit. Pages I and 3 should be filed within 'Department of Health and Montal Hygiene. Important: If tiem 27 is marked other than injury or other traumatic event, the Medica		21. Signature of Furneral Service Licensee	CFS P 50	olloway Ol Snow	Funera Hill Ro	l Home Pr	ofessiona burv, MD	al Association 21804				
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		or condition resulting in death) Due to (or as a consequence by	ce of):									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ce of):									
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O, e be ex ysician burial	edical	UNPENDED AMENDED										
876 rtificat ing phy as the	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of p		al death 3	Ectopic pre	egnancy	23d. Date of d Month	elivery Day Year				
ox 6876C eath certificate attending phys for use as the b	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	f death 5 Oth	ner (Specify)								
Records, P.O. Box 6876. The law requires that the death certificate cate has been signed by the attending phypage 2 should be detached for use as the l		Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?				
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Vital Reystician: The his certificate director, page	BeC	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2			of Death (Che							
f Vi Physi er this	ပ	1 Yes 2 No Inpatient 2 27. Manner of Death 28a. Date of Injury	✓ ER/Outpatient 28b. Time of Ir		y at Work?	rsing Home 5	Residence 6 how injury occurred	Other:				
Division of Vital Records, rate or attending Physician: The law requires and cortect that a Director: After this certificate has been seen in the funeral director, page 2 should the	ertification:	1 Natural 5 Pending Jun 25, 2010	1219 hrs		′es 2 ✓ No	Driver of au	to auto collisio					
ivisior or Attend after death Director:	ifica	2 🗹 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - A	at home, farm, stree	t, factory, office b	uilding, etc.	28f. Location (or Town, S		or Rural Route Number, City				
Di spital	Cert	4 Homicide determined (Specify) Major R	oad / Highway			Westbound R	Route 50 at 60 Fo	oot Rd, Pittsville, MD				
Division of Vital I To the Hospital or attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination	-									
To with To com	Med	29b. Signature and title of certifier	_	29c. License	e number		29d. Date signed	(Month, Day, Year)				
a		Patin - Palo-	C 1m	O.C.I	И.E.		June 26, 20	10				
lan		30. Name and address of person who completed cause of death (I		444.5: 5:		140 0400	4					
Ja,	ate	Patricia Aronica-Pollak MD. Assistant Medic. 31. Date filed (Month, Day, Year) 32. Pigistrar's Sign		TTT Penn St	eet, Baltin	nore, MD 2120						
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 July 2 Stella Anne Overman Virts 09:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood At Crumland Farms Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours February 27 Months Director 220-09-2760 95 1915 North Carolina Usual Residence of Decedent 28a-f shor 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 23a or 3 10f. Zip Code 10g, Citizen of What Country? Funeral 7407 Willow Road 21702 United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married 'natural", or Ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3X Widowed 4 ☐ Divorced Specify: Completed White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Designer Religious Suppliers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Samuel Overman Stella Pearl Liskey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Charles Clifton Virts, III / Son 1010 Lindfield Drive, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Smithsburg Crematory | July 5, 2010 Smithsburg, Maryland 21. Signature of Funeral Service Lig Keeney and Basford PA Funeral Home. MO1473 Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a configuence of); disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any loading to in necleta cause. Enter Underlying Examin Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 month 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed ten 56 on 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director. Be 26. Place of Death (Check only one) examiner? ဂ္ 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours e Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on d title of certifier Sheh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) redesour State

Dir

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Charles Williams 5:40A M Physician/ 2010 Jung Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** andallstown Taltamore orthwes T If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Min JULY 17, Year 1953 1 😾 M 2 🗆 F 56 Yrs MARYTAND Director 213-60-5346 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1X Yes 2 ☐ No BALTIMORE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3710 DORCHESTER ROAD 21215 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. δ 1 X Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 ygiene. her than "natural", c it, the Medical Exarr 1 ☐ Yes 2X No Specify. Specify: BLACK Year or Dates. 1972-91 Completed 3 Widowed 4 Divorced 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) SIGNALMAN NAVY 12 I Hygie Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or con-0 CHARLES HENRY WILLIAMS GWENDOLYN GENEVA BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) EVETTA RICHARDSON / SISTER 228 SUPERIOR STREET, HAVRE DE GRACE, MD 21078 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 06/25/10 WEST CHESTER, PA 4 Donation 5 Other (Specify) R.A. FERRIS & CO. 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE 21. Signature of Funeral Service Licenses P.A MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepatocellular (arcinoma. Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 2 🗌 No 1 Tes 26. Place of Death (Check only one) ours after death. eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical Be Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) examiner? Hospital: 1 🗌 Yes 2 🗂 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending injury 1 Natural 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

3+1VA

Registrar

DHMH 17 Rev 7/2009

State

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

USRajapahne M.D

N.S. RayapakseMD

JUN 2 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smili

2835

32. Registrar's Signature

00057465

29d. Date signed (Month, Day, Year)

N-5-235-Baltimore, MD. 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#18perfuneralhome7/2/10etificate pof Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 24/2010 7:25pm ^M Edward Lee Whitsett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4009 Tahoe Place Charles White Plains 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1X M 2 🗆 I 10-17-1929 245-30-7108 80 **Director** NC Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Charles White Plains 1X Yes 2 No ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 4009 Tahoe Place 20695 USA death \ 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. "natural", Completed Specify: Black 3 - Widowed 4 - Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Produce Private 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surpame)
Cora Tucker Chestnut Edward Lee Whitsett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4009 Tahoe Place, White Plains MD 20695 Gloria Whitsett/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Harmony 6/30/201**q** 4 Donation 5 Other (Specify) Cemetery Landover, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd, Waldorf Md 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician NI disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause Enter Ordenning Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed the burial-tran signed by the attending physician and be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Nonknown . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? this certificate 1 Yes 2 No Yes director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, nours after death.

neral Director; After this filled in by the funeral d 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month

gistrar's Signature

28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amended#19a perFH FCHD, KS 6/29/10

Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WACKER ARBARA MEADOWS Month 6:00 A M TONE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OLNEY. MONTGOMERY GEN BRAC HOSPITAL MONTGOMER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Days Hours June 14, 74 Virginia Director 236-52-0672 West 936 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Tes 2 X No Maryland | Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1445 Old Annapolis Road 21797 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Year or Dates White of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Catholic University Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles W. Meadows Mabel Johnson plnods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1445 Old Annapolis Road, Woodbine, Maryland permit. Page 1 and 2 Ronald E. Walker - Son Husband 21797 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o ö cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Crestlawn Mem. Gardens 6/26/10 Marriottsville, Maryland 21. Signa ure of Funeral Service Licensee 22 Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final TEARMIH Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year ate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☑ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by UMATOIL 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29c. License number

State Registrar 30. Name and address of person

31. Date filed (Month

Registrar's Signature

of death (Item 23a) (Type, Print) NO PRINCE PHILIP DR. 12300 OLWEY

MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2010 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6/22/2010 Physician/ Jack R. Winemiller, Sr. 4:20anM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XX 2 - F Months Hours Min. Director 214-48-2119 63 DC Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a, State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes XX No MD Lothian Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 West Bay Front Rd. 20711 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 ☐ Never Married 2 本 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 - Widowed 4 - Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Auto Body Mechanic Auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wilson Winemiller Norma Keene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. Winemiller Wife 19 West Bay Front Rd. Lothian , MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 7/3/2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween anset and Death Immediate Cause (Final Physician/ disease or condition Monta Medical resulting in death) Due to (or as a considence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perfor death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-X Natural 5 \square Pending work 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar 29b, Signature and title of certifier

Panine

anine werny 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Ma	aryland /	Department of Certificate		Mental Hyg	iene 2010	21708
	Physicia	an	1. Decedent's Name (First, Middle, Last) Darnell White				2. Date of Death	Dav Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)		4b. City, Tov	wn, or Location of Deatl	June	19 2010 4c. County of Death	3:13 PM
	Examin	er	St. Agnes Hospital		Boltin	nore		N/A	
	Funeral Director		5. Social Security Number 16. Sex 216-86-3269 1□ M 2점 F	e (In yrs. last 39	birthday) If Under 1 Y Yrs. Months D	Year If Under 24 Hrs. Pays Hours Min.		Year) 19/0 Mar	pplace (State or Foreign intry) Yland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	Maryl I-f sho	ţ	Maryland N/A	Ва	ltimore				1 □Yes 2 X No
	or 28s	Director	10e. Street and Number		10f. Zip Co		11	Og. Citizen of What Cou	intry?
	s 23a	eral	2914 Mallview Rd.	Suprin II C		1230	Procify Ves or No-	USA 14. Race - Amer	ican Indian
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examinations to retified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced· 12. Was Decedent: 1 □ Yes 2 ▼ 1 □ Yes 2 ▼ 1 □ Yes, Give Year or Dates:		If Yes, specify 1 □ Yes 2X	t of Hispanic Orlgin? (S Cuban, Mexican, Puert]No <i>Specify:</i>	to Rican, etc.)	Black, White	, etc.
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	1	6a. Decedent's Usual C	ione durina most of wor		16b. Kind of Business/I	ndustry
121	within iene. than '	Completed	Elementary/Secondary (0-12) College (1-4or 5 O	,+)	'life. DO NOT use r Bus Ai	<i>'</i>		Smith Bus	Co.
Jd 2	e filed al Hyg other vent, I	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nar	me (First, Middle, M	Maiden Surname)	
ylaı	ould by Menta	To E	Lionel Scott			Maxine			
Mar	d 2 sh Ith and I 7 is rr traum		19a. Informant's Name/Relationship (Type. Print) Michael White(Spouse)		19b. Mailing Address <i>(S</i> 2914 Mall			; City or Town, State, 2 .ore,Md.	•
re,	s 1 an of Heal item 2		20a. Method of Disposition		e of Disposition (Name etery, crematory or othe			20c. Location - City or	
i E	Page ment c ant: If ury or		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ws U.M. C	hurch 6-2		West Rive	
Baltimore, Maryland 21215-0036	permit. Departi Importi any inj		21. Signature of Funeral Service Licensee	8-3				ary, P.A., Md. 214	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each life	i the death. [ne.	Do not enter the mode of	of dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
4	Physician		resulting in death)	iest.	Concer				unkn-un
	/Medical Examiner		Due to (or as	a consequen	ce of):				
	± +	ner	Sequentially list conditions, if any, leading to immediate cause. Clisease or injury that initiated events.	a consequen	ce of):				
	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as	a consequen	ce of):				
8760,	ficate be executed physician and s the burial-transit		d d	a consequent	00 01/.				
9	tificate ng phy as the	Medical	u						
P.O. Box	Physician: The law requires that the death certifi this certificate has been signed by the attending i al director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	eath 3 Ectopic preg			23d. Date of del Month	ivery Day Year
	signed by	þ	Part II. Other significant conditions contributing to death b	ut not resultin	ng in the underlying caus	se given in Part I.		bacco use contribute to es 2 □ No 3 □ Pr	the cause of death?
)arne// Vital Records,	w requir s been si should l	Completed					24a. Was a		itopsy findings available
) e/ I Re	The la ate ha	Somp					autops perfori 1 □Yes		completion of cause of 2 □ No
arne Vital B	iclan: sertific ector, I	Be C	25. Was case referred to medical examiner?			26. Place of De	ath (Check only on	ne)	
→ ₹	Physical direction	2	27. Manner of Death 28a. Date of Inju	ury 28	I/Outpatient 3 □ DOA Bb. Time of 28c	4 Nursing I Injury at Work?		ence 6 Other (Spe	cify)
fe ion	Attending r death. ector: After by the funer	ation	1 ☑ Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	y, Year)	Injury M	Work? 1 □ Yes 2 □ No			
luhite Division	l or Atte after de: Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inj building, et	ury - At home c. (Specify)	e, farm, street, factory, o	ffice	28f. Location (S. City or Town	treet and Number or Re n, State)	ıral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of the desired and manner st and manner st	of examination					
	To the within To the comple	Mec	29b. Signature and title of certifier	A 1 (29c. L	icense number	2	29d. Date signed (Mont	h, Day, Year)
	•		1 my Com	Mel	0	50297		June 19	12010
()	iLa		30. Name and address of person who completed cause of c		S. Agrei	31	TMLAC	MARYC	there)
7	Sta	ite	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	S. parl			1	
	Registr	ar	JUN 2 4 2010	wa ,	s. garas	<u> </u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ALPHONSE WILLIAMS 20 2010 2010 JR. JUNE 21:03 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number Age (In yrs, last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** Months Days 1274, 171947 62 MISSTSSIPPI **Director** 427-98-4702 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland ith and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo PRINCE GEORGES MD GLENN DALE 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 12308 JAMES MADISON LANE 20769 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE CONSTRUCTION permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ALPHONSE WILLIAMS SR. LILLIE MAE TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12308 JAMES MADISON LANE, GLENN DALE, MD 20769 DIANE Ε. WILLIAMS/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 06/29/2010 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MARYLAND 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER RD., LANDOVER, MD Approximate Interval Between Onset and Death MONTH 23a. Part 1. Enter the descape, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ BACTERIAL ENDOCARDITIS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** INFECTED LEFT FOOT ULCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buria Medical P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown g Unknown signed b Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ END-STAGE RENAL DISEASE ON HEMODIALYSIS / Records, 1 ☐ Yes 2 ☐ No 3 ♣ Probably 4 ☐ Unknown Completed EMBOLIC CVA 2° BACTERIAL ENDOCARDITIS/ SEPSIS / 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed Yes 24 BACTEREMIA certificate 2 🗆 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 - ER/Outpatient 3 - DOA ၉ this 27. Manner of Death 1 🗡 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 5 Pending 2 Accident 1 Yes 2 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATHLEEN PETRO, MD. 7600 CARROLL AVE, TAKOMA PARK, MD 20912 31. Date filed (Month, Day, Yes State

DHMH 17 Rev 7/2009

Registrar

JUN 2 9 2010

10-04973 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jennifer Lynn Watson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 2, 2010 Medical Examiner 2325 hrs Jennifer Lynn Watson 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Fikton Cecil Union Hospital 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Director Country)Maryland 2 X F 216-17-8485 1 M 29 02/15/1981 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 No E1kton Maryland Cecil Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Thyme Street United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Retail Sales Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Steve Whalen Barbara Bandy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Whalen/Mother Thyme Street, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) July 71 X Burial 2 Cremation 3 Removal from State Union Cemetery 2010 4 Donation 5 Other Specify: Union, MD 22 Name and Address of Facility Hicks Home for unerals, 21. Sig ture of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 0 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Verapamil intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician and or use as the bunal - transi Physician/Medical UNPENDED AMENDED 27,28a-f,per Me g905 7/22/10 TT IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 V Unknown Unknown the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been submeral director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Other₄ Hospital: 1 Inpatient Nursing Home 5 Residence 6 Other: 2 🗸 ER/Outpatient 3 1 🗸 Yes 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural subject overdosed death. Director: d in by the f 5 Pending 1 Yes 2 X No Fd 7/2/10 Fd 8:00 pm 2 Accident Investigation 3 X Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) I Thyme St 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Dire 6 Could not be E1K Town, State MD determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E July 3, 2010 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 20 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 455 M bert ando Medical 4a. Facility Name (if not institution, give street and number **Examiner** Town, or Location of Death 4c. County of Death 100 Roa CP George 8. Date of Birth _(Month, Day, 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. If Under Birthplace (State or Foreign Country) **Funeral** 1 M 2 - F Months Days Hours Min. Director Yrs. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 No If Yes, Give Year or Dates Specify. Specify: 3 Divorced 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) REStoration Be 17. Father's Name (First, Middle, Last) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Crenation 4 ☐ Donation 5 ☐ Other (Specify) 6/28/10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, P. A Funeral washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AThoroscher disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate 2 🗌 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this a funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending within 24 hours after death.

To the Funeral Director: As completed filled in by the fu 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1405 3001 Salvader 31. Date filed (Month, Dav. Year) 32. Rg State JUN 38 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Barbara 25^{ay} June 20 TO Ziegler 5:00 a. M Medical 4a. Facility Name (if not institution, give street end number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12 Bellevue Avenue Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months May 18, Tear) 1 □ M 2 F Hours Pennsylvania 212-32-4833 Director 84 Usual Residence of Decedent items 23a or 28a-f shov if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Bellevue Avenue 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc 1X Never Married 2 ☐ Married Completed by 3altimore, Maryland 21215-0036 1 Yes : 2 X No white 1 Yes 2 X No Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) bacteriologist hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be George Raymond Ziegler Rebecca Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health ar ant: If item 27 is Roy Frick 9927 Stephen Decatur Hwy. Ste. G13, Ocean City, MD p.r. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 🗶 Burial 2 🗌 Cremation 3 🗋 Removal from State Department of Important: If any injury or Cambridge Cemetery 6/30/10 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 13 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Chronic d bs frac tre Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner enocalemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical certificate be Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Hospital or Attending Physician: The law requires that the death o in the past 12 months? Month Year Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown signed by t Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? 1 Yes 2 AN Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred atural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

ul

TITANOUT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BYRN

29c. License number

ST CAMBRIDGE MD 216/3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ July 2010 Zentner Robert 2:10 AMMedical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Homewood at Crumland Farms 8. Date of Birth Nov - 20 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Year 1922 **Funeral** Days Min. 1 ₹ M 2 ☐ F Wisconsin Director 396-16-7500 87 Usual Residence of Decedent Show 10d. Inside City Limits or 28a-f show notified at 10c. City, Town or Location 10a. State with the Maryland Director 1 🗆 Yes 2 🔀 No Frederick Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō "natural", or items 23a or edical Examiner must be 21702 Funeral 7401 Willow Road, Apt. 453 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. ıı Yes, Give Year or Dates,1944**-1**946 White 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "niany injury or other traumatic event; the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Government Physicist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Amanda Budzien ပ္ John Peter Zentner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7401 Willow Road, Apt. 453, Frederick, MD 21702 Mrs. Barbara C. Zentner, wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Mount Olivet Cemetery July 10, 2010 Frederick, MD 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22 Weenerganta Basford PA Funeral Home of Puneral Service L M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one/cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner ta (or as a consequence of) KINS N) MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accide 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying furse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 10062423 July 7, 2010

State Registrar

DHMH 17 Rev 7/2009

PREDERICE, MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

2 AYEEN BOLANUM

31. Date filed (Month, Day, Year)

Gerson Alexand		1- For State		of Maryla	and / L		ment of icate of		and	Menta	il Hygier		g. No.			
Physici	an/	1. Decedent's Nam				_ 1					Mon	of Death	Day	Year	3	3. Time of Death 0245 hrs
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		University h		ve street and no	imber)		"	Baltimo		Cattori or L	Death		1	ı/a	Galli	
Funeral		5. Social Security I	Number 6. S	ex	7. Age (Ir	n yrs. last	birthday)	If Under		If Under 2	24Hrs. 8. Da	te of Birth	h(MM/DI		. Birthporeign	place (State or
Director		622-46-8	743 15	M 2 F			19 Yrs.	Months	Days	Hours	Ju	ne l	9,19		Coun	itry) CA
ź.		Usual Residence of	of Decedent 10b. County		1100	c City To	wn or Location	n				10d. Inside City Limi				
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit reges I and 2 should be filed within 72 hours after death with the Maryland pertainment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Marri	ind 3 Marris	12. Was De		er in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc.									in Indian, Black,	
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e, N l and Health 'item		20a. Method of Dis	·				e of Disposinatory or other		of ceme	tery,	Date July	15.	20c. Lo	cation - Cit	y or To	own, State
MOF Pages ent of int: If		1 Burial 2 4 Donation 5	Other Specific		om State		Nation		m.Pa	rk	2010		Lau	rel,	MD	
Baltimore, permit. Pages I an Department of Hee Important: If ite		21. Signature of Fu	neral Service Lice	nsee		L										e, P.A.
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Physician /Medical		23a Part I. Enter the failure. List or	nly one cause on e	ach line.		death. Do	not enter th	e mode of c	iying, su	ich as card	liac or respira	itory arre	st, snoci	k, or neart		Approximate Interval Between Onset and Death
Examiner		Immediate Cause or condition resulti	(Multiple Inj		ence of):									-	Death
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0, e be ex	ledical	UNPENDED		AMENDED												
Sox 68760, leath certificate be e attending physici for use as the buri	Ě	IF FEMALE: 23b. Was decedent	pregnant in the	23c. If yes,	outcome coirth	of pregnan		al death	3	Ectopic pr	regnancy			Date of del Ionth	ivery Dag	y Year
	icia	past 12 months			nant at time	e of death	5 Oth	er (Specify)				1			
. Bo he dea y the a hed fo	Physician/M	Part II. Other signi	No 9 Unknow	9OIIKII		.t .c.at .c.al	ting in the	doduina os		an in Doct I	1 22	a Did tok	haccous	e contribut	e to th	e cause of death?
Division of Vital Records, P.O. Box 6876 tal o Attending Physician: The law requires that the death certificat is after death. al Director After this certificate has been signed by the attending phyled in by the funeral director, page 2 should be detached for use as the	ρ	Part II. Other sign	meant conditions	contributing to	o death bu	i nocresui	ung in the ui	idenying ca	iuse give	BII III F AIL I	1	.—				oly 4 🗸 Unknown
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l Re a: The tificate or, pag	ပ္ပ	25. Was case refer	red to medical					26.	Place of	Death (Ch	neck only one	Yes 2	No.	1 🗸	Yes	2 No
Vita ysician his cer direct	o Be	examiner?		Hospital: 1	Inpatient	2 🗸 ER	/Outpatient		_		lursing Home	_	Residenc	ce 6 C	Other:	N
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ivis lo A affer d di by	Certification:	3 Suicide	6 Could not determine	be 28e. Plac			, farm, street	, factory, of	fice buil	ding, etc.	or	Town, Sta	ate)			I Route Number, City
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Division of Vital Records, P.O. Box To the Hospital of Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director. After this certificate has been signed by the atternoonpletely filled it by the funeral director, page 2 should be detached for use	Medical	(Check only one) 2	Certifying Physic Medical Examine	r:On the basis	of examina											
To Cor	Me	29b. Signature and	title of certifier	and manner s	stated.			29c. L	icense r	number			29d. Da	ate signed	(Montl	h, Day, Year)
		1	2 11	K	70.		Ker		D.C.M.	Ε.	OCME		July 9	9, 2010		
_ \	ŀ	30. Name and addr														
	لِ		1. King, Jr., Mi		ant Med					et, Baltir	more, MD	21201				
St Regist	ate rar	31. Date filed (Mon	JUL 13	2010 2	erstrar's S	Signature /	1. 16	erled	9							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{\mathsf{Day}}{2}\underline{010}$ Physician/ Month A^{M} Gene E. Antoniacci July 7:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House
Social Security Number 6. Sex 7. Age (In yrs. last Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, 1 X M 2 - F Months Pennsylvania Director 184-24-7587 78 October Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Montgomery Derwood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 6909 Horizon Terrace 20855 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 X No Specify. Year or Dates. Korea 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Attorney Lega1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Merr Important: If item 27 is marke any injury or other traumatic. other traumatic Gino G. Antoniacci Helen Filipski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Patricia Antoniacci/W</u>ife 6909 Horizon Terrace, Derwood, Maryland 20855 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July Datel. cemetery, crematory or other place) 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Urosepsis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Parkinson's Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Lewy Body Dementia that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical that the death certificate be 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death 9 Unknown 9 Unknown P.O. ò signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 ☐ No 3 ☐ Probably 4X Unknown been sign 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an nas page 2 autopsy performed? Yes 2 X No certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\bar{\text{X}}\) Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 24 hours after death.
Funeral Director; After this eted filled in by the funeral of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the comple only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D0060634 July 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Bindu

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31. Date filed (Month, Day, Year)

Joseph,

32. Registrar's Signature

6001 Muncaster Mill Road, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Z. Arnold 11:11 P M July 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7408 Honesty Way Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗓 F Months (Month, Day, Year) Hours Min. Director 220-46-2237 Illinois March 19 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 23a r than "natural", or items 23 the Medical Examiner must 7408 Honesty Way 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces , or Black, White, etc. 1 Never Married 2 Married Yes 2 X No þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Dental Lab Technician Dental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o ည Arthur C. Zoller <u>Margaret Emerson</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Judy Hewitt/Daughter 7408 Honesty Way, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium. Inc. June 9, 2010 Bethesda, Maryland 21. Signatur of Funeral Service 22. Name and Address of Facility Robert A. Pumphrey Funeral Home. Bethesda-Chevy Chase, Inc. M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition 3 Months Physician/ Colon Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 🖾 No Pregnant at time of death Month Day Year detached s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performe death? this certificate 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

10 V

31. Date filed (Month, Day, Year) State

Ralph V. Boccia, M.D.

29b. Signature and the

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D29675

6420 Rockledge Drive #4100, Bethesda, Maryland 20817

29d. Date signed (Month, Day, Year)

July 8, 2010

10-05088 Alice Ann Brunzell

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Š	State of Maryland / Department of Health and Mental Hygiene		20	0	21	
	Certificate of Death	Peg No		1		

		Registrar Certificate of Death	Reg. No.					
Physicia Medical Exami	in/	1. Decedent's Name (First, Middle,Last) Alice - Ann Brunzell	2. Date of Dea Month July 7, 20	Dav Year	3 Time of Death 0956 hrs			
			b. City, Town, or Location of Death Gaithersburg Montgomery					
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8 Date of B	irth (MM/DD/YYYY) 9. Bir	rthplace (State or			
Funeral Director		Months Days Hours	Min.	Forei	gn ountry)			
Birector		518-01-8292 1 M 2 F 91 Yrs	May 2	5, 1919 L ~	Idaho			
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Maryland 28a-f show d at once.	ğ	Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	intry?			
e Mar or 28a fied at	Director							
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r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pu		White, etc.	rear matair, black,			
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5-0036 led within 72 hours after Hygiene. other than "natural",	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use	retired)		4			
0036 within 72 iene. er than Medical	힐	3 Executive Secretar	cy	Trade Ass	ociation			
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	녌	17. Father's Name (First, Middle, Last) 18.Mother's N	ame (First, Middle,	Maiden Surname)				
215 be fill ntal H rked ent, g	Be	Herbert Duncan Martin Maud			esong			
MD 21215-0036 2 should be flied within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sh matic event, the Medical Examiner must be notified at once	의	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route Nu	imber, City or Town, State	e, Zip Code)			
MD id 2 shoulth and in 27 is aumati		David L. Brunzell/son 8504 Guertin Court		k, Maryland				
re, s l an f Hea If iter		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	Town, State			
Baltimore, MD 21215-0 permit Pages I and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumaric event, the L		4 Donation 5 Other Specify: Final Journey Crematory	7/10/201	0 Woodbine	, Maryland			
Balti permit. Departn Imports injury o		21 Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremat	ion Serv	ice P.O. Bo	x 784			
W 8 9 E .s.	_{	M00957 Beverly L. Heckro	otte, P.A	. Clarksvil	le, MD 21029 Approximate Interval			
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8760, tificate be ng physici as the buri	₩.	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of deliver	*			
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Division of Vital Records, ral or Attending Physician: The law requir rs after death. al Director: After this certificate has been s led in by the funeral director, page 2 should!		25. Was case referred to medical 26.Place of Death (Ch			Venezal			
Vital Physician: this certifi	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 No	ursing Home 5	Residence 6 🗸 Othe	er: Scene			
of ing Pt After uneral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? FOUND: 28d. Day. Year) FOUND: 28d. Injury at Work?	Subject fel	how injury occurred I striking head on f	urniture			
ion tendi tor: /	랿	1 Natural 5 Pending FOUND: 1 Yes 2 No No No Not Not Not Not Not Not Not No)					
ViS or At after d Direc in by	<u>ij</u>	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		(Street and Number or R State)				
pital jours grital filled	Certification:	4 Homicide determined (Specify) Multi-Family Apt.		State) Road #903, Gaitherst				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	29a Getifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Checkon) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurring	and due to the cau red at the time, dat	use(s) and manner as sta e and place, and due to t	nted he cause(s)			
To T	Med	and manner stated 29b. Signature and title of certifier 29c. License number		29d. Date signed (M				
	100	O.C.M.E.		July 8, 2010				
		30. Name and address of person who completed cause of death (Item 23a)						
5		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201					
	ate							
Regis	trar	JUL 13 2010 General B. Maria						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20% 15401 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Northwest Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 07-07-68 Days Hours Min. 42 MD Director 218-02-1096 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Funeral Director 1 X Yes 2 □ No Baltimore MD NA 10g. Citizen of What Country? 10f. Zin Code 10e, Street and Number USA 21201 521 Half Circle 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces 7 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. African 1 Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: American Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Shop Repairman 8th Grade Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Burrell, Trina Davis Τ. Roger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2407 Elsinore Avenue Baltimore, MD 21216 <u>Kimlee Savage-C</u>ousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date Trinity 1 🔀 🛱 (irial 2 🗆 Cremation 3 🗆 Removal from State 07-15-10 Baltimore, MD Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Servic Censes Street Baltimore, MD 21217 638 Gilmor ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only op cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) anc Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 2 🗌 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospita Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Pr address of person

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 1 0 State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 03, 2010 11:04AM Bell Mary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Timonium Stella Maris Hospice Center g. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours 08-01-58 1 M 2 🔀 F 51 MD 212-74-4332 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director XX Yes 2 No MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21206 5403 <u> Moores Run</u> Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. African þ 1 X Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: American 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Exit Right Realty 12th Grade <u>Assistant</u> Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Bel1 Elizabeth Daniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Graton Road Baltimore, MD 21206 5107 Terry Avreonna 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State Mt. Zion Cem. 07-16-10 Lansdowne, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Home P.A. 638 Ν. Gilmor Street Baltimore, MD 21217 23a. Fart 1. Enter the disease, or complica ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate se on each line shock, or heart failure. List only one Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical MACH しんしいivision of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence ☑ Oth<u>er (Specify)</u> 6 this 28a. Date of injury (Month, Day, Year) 27. Manner of De 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After t injury 5 Pending Natural Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29c. License numbe 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) mmillem Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh g905 7-14-10 vt State of Maryland / Department of Health and Mental Hygien 0 | 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\overset{ ext{Month}}{ ext{Julv}}$ Burton 20°10 Donald 10:20PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Rock Glen Nursing & Rehab Ctn. Baltimore If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Sex 1 X M 2 □ Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Manth, Pay, Year) 5 Hours Maryland 45 Director 217-84-4722 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 ☐ Yes 2X No Baltimore MD Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6943 McLean Blvd 21234 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces 7

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 2 🔀 No ☐ Yes Specify: American 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade NA <u>Manager</u> Walmart Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leon E. Burton <u>Sarah M.</u> Moses 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hanifah Winder 204 Maine Avenue Baltimore, MD 21207 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Rurial 2 Cremation 3 Removal from State cemetery, c matory or other place) King Mem.Pk.Cem 07-14-10 Randallstown, Donation 5 Other (Specify) Wylie Funeral Home P.A. . Signature of Funeral Service Licenses 22. Name and Address of Facility 638 Street Baltimore, MD 21217 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine nsequence of Due to (or as a co the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Month Year 2 No detached 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 4 Unknown 1 Tyes 2 No 3 Probably within 24 hours after death.

To the Funeral Director. After this certificate has been siy completed filled in by the funeral director, page 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 2 1 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending 1 Yes 2 No М 2 Accident
3 Suicide Investigation 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) ature and title of certifier 29d. Date signed (Month, Day, Year) 29b. Sign 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's State 3 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-04751 State of Maryland / Department of Health and Mental Hygiene 2010 Lenwood Brown 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month June 24, 2010 Medical Examiner Lenwood Brown 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring 1316 Fenwick Lane #905 8 Date of Birth (MM/DD/YYYY 5. Social Security Number 10K 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 75 Sept 12, 1934 Yrs 1X M 2 F Usual Residence of Decedent 10c. City. Town or Location any 10b. County 10a. State Silver Spring imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

The state of the Art MD Montgomery Director 10f. Zip Code 10e. Street and Number 20910 USA 1316 Fenwick Lane #905 Funeral 12. Was Decedent Ever in U.S Armed Forces UNK 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 No Yes 1 Yes 2 X No specify: If Yes, Give Year ģ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) unk unk 17. Father's Name (First, Middle, Last) UTIK 19a. Informant's Name/Relationship (Type, Print) ၉ O.C.M.E. 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: I 4 Donation & X Other Specify: in state 21. Signature q Funeral Service Licer Danie (A) Naylor that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications Physician /Medical Hyperthermia complicating Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED UNPENDED attending physician or use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 9 the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ σ. Diabetes 24a. Was an autopsy death? performed?

9. Birthplace (State or unk Country) 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? 14 Race - American Indian, Black, Specify: black 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk18.Mother's Name (First, Middle, Maiden Surname) UNK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street; Baltimore, Maryland 21201 20c. Location - City or Town, State 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Approximate Interval Retween Onset and Death The law requires that the death certificate be executed Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available certificate has been prior to completion of cause of No Yes 2 No 1 🗸 Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? After 27. Manner of Death 28b. Time of Injury Exposed to high environmental temperatures FOUND: Natural 1 Yes 2 V No Pending 24 hours after death. To the Funeral Director: Jun 24, 2010 1540 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 1316 Fenwick Lane #905, Silver Spring, MD Suicide determined (Specify) Multi-Family Apt. Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 25, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Jack Titus MD. State 31. Date filed (Month Day, Year distrar's Signature Registrar

1540 hrs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical (if not institution, give street and number, 4b. City, Town, or Location of Death ounty of Deal **Examiner** Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 M Months Days Hours Min Yrs. **Director** 28a-f show 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10f. Zip Code 10e, Street and Numb ō 10g. Citizen of What Country? Funeral 23a 21 items 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 ☐ No Completed by 1 Never Married 2 Married "natural", or 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind, of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kipchof Business Industry (Specify only highest grade completed) than " Elementary 96 (0-12) College (1-4 or 5+) and 2 should be filed within Health and Mental Hygiene. is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) er's Name (First, Middle, Maide 19b. Mailing Address Street and Number Important; If item 27 sposition Department of permit. Page 1 2 Cremation 3 Removal Donation 5 Other (Specify) of Funeral Service Lice Sic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WESK Immediate Cause (Final Physician/ disease or condition resulting in death) LARCON OMA 1EMSMTDE Medical Examiner Esqueritially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ► No Month 5 Other (specify) Pregnant at time of death 9 Unknown is certificate has been signed by the a director, page 2 should be detached 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 1211 certificate DASSIE 1 Yes 2 No 2 🖪 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred : After t Certificate: work? 1 D Natural 5 Pending 2 No Accident Investigation 6 Could not be within 24 hours after deat To the Funeral Director. Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 29a. Certifier 🙅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ortly one Certifying Nurse Fractioner T. the best of my knowledge, death occurred at the fine date and place and due to the cause(s) and conner as stated 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106

State Registrar 31. Date filed (Month

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amend #state of Maryland 7 Department of Health and Mental Hygiene 2010 21723

		1- For State Registrar	ertificate of	Death		Re	eg. No.	10 21720					
Physicia	in/	Decedent's Name (First, Middle,Last)			•	Date of Deal Month	th Day Yea	3. Time of Death					
dical Exami	ner	Kenneth Bugglen, Sr.		41. O't. Town or	Landing of De	July 8, 20	10 4c. County of	1010 hrs					
		4a. Facility Name (if not institution, give street and number) 208 South Payson Street Apt 5		Baltimore	Location of De		N/A						
Funeral			s. last birthday)	If Under 1 Year Months Days			`	9. Birthplace (State or Foreign					
Director		220-11-9246 1XM 2 F 33	Yrs.		1	0ct. 1	2, 1976	Country) MD					
any		Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Locati	on				10d. Inside City Limits					
		N/A	ooklyn	Baltin	nore			1 Yes Z No					
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show in other traumatic event, the Medical Extransive must be notified at once.	Director	10e. Street and Number 104 12th Ave. 2548 Wilkens Av	ve.	10f. Zip Code 21225	21223	3	0g. Citizen of Wh	nat Country?					
with the same se not		11. Marital Status 12. Was Decedent Ever in				(Specify Yes or No		- American Indian, Black,					
death r iten	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No.		es, specify Cuban	, Mexican, Pu	erto Rican, etc.)	vvnite	e, etc.					
after	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No			Specify:	White					
hours 'natur		Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		t's Usual Occupati ost of working life.			16b. Kind of Bu	.siness/industry					
36 thin 72 than than edical	ple	Elementary/Secondary (0-12) College (1-4 or 5+)	Sales	;			Office	Furniture					
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be Completed	17. Father's Name (First, Middle, Last) Nelson D. Bugglen, Jr.			18 Mother's Na Denis	ame (First, Middle, I e Tippie	Maiden Surname)					
MD 212 nd 2 should b ulth and Meni m 27 is mark	70	19a. Informant's Name/Relationship (Type, Print) Kena Bugglen, wife	19b. Mailing 104 1	Address (Stree 2th Ave.	t and Number Broo	or Rural Route Num klyn, MD.	nber, City or Tow 21225	n, State, Zip Code)					
ore, ML is 1 and 2 s of Health ar If item 27			b. Place of Disposi			Date		ation - City or Town, State					
Baltimore, permit. Pages I at Department of He. Important: If ite		4 Donation 5 Other Specify:	crematory or oth Atlantic	Cremator	y 0	7-11-2010	Glen	Burnie, MD					
Baltil permit Departm Importa		21. Signature of Funeral Service Licensee	22 N An	lame and Address	of Facility neral	Home, Inc	3.						
0 8 8 5 5 5		Freder To	la. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval										
Physician // Medical		failure. List only one cause on each line. Combine	d Drug I	ntoxicat	ion(Do	xylamine,	est, snock, or nea	Between Onset and Death					
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	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause											
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60, ate be e ohysicia ne buria	edical	IF FEMALE: 23c. If yes, outcome of pr		r ber me	g300 (5-24-10 V	23d. Date of	f delivery					
876 rtificat ing phy as the	an/M	23b. Was decedent pregnant in the past 12 months?	2 Fe		Ectopic pre	egnancy	Month	Day Year					
Box 687 e death certific the attending	/sician/	4 Pregnant at time of	f death 5 Otl	her (S <i>pecify</i>)									
D. Be tr the de by the ached f	Phy	Part II. Other significant conditions contributing to death but no	ot resulting in the u	inderlying cause g	iven in Part I.	23e. Did to	obacco use contri	ribute to the cause of death?					
P.O. ires that to signed b	þ			, .			s 2 No 3	Probably 4 V Unknown					
rds, require been si	Completed					24a. Was		Were autopsy findings available					
COF law r e has t	ğ						rmed?	prior to completion of cause of death? Yes 2 No					
of Vital Records, ng Physician: The law requirements certificate has been sineral director, page 2 should be neveral director, page 2 should be neveral director.		25. Was case referred to medical		26.Place	of Death (Ch	1 Yes	2 NO 1	Yes 2 No					
/ita ysiciar his cer directe) Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other Nu	ursing Home 5	Residence 6	✓ Other, Scene					
of of ing Phy	1: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of I	njury 28c. Injur	ry at Work?	28d. Describe	how injury occurr	red					
on tendin sath. or: A	ţi	Natural 5 Pending fd 7-8-10	£d 10:0	0 a 1 1 1	res 2 X No	unknown	1						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - A	t home, farm, stree	et, factory, office b	uilding, etc.	28f. Location (or Town, S Baltin	Street and Numb State) 208 nore, Md	ser or Rural Route Number, City South Payson #5 - 21223					
To the Hosp within 24 hos To the Fune completely fi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	rledge, death occur on and/or investigat	red at the time, dation, in my opinion	ate and place, , death occurr	and due to the caus red at the time, date	se(s) and manner and place, and d	r as stated. due to the cause(s)					
To To	Me	29b. Signature and title of certifier		29c. Licens	e number	00117	29d. Date sign	ned (Month, Day, Year)					
		The Some U. K. A TO	14.	O.C.I	M.E.	OCME	July 9, 201	0					
		30. Name and address of person who completed cause of death (If Theodore M. King, Jr., MD. Assistant Medica	ŕ	111 Penn Str	eet, Baltin	nore, MD 2120	1						
S	ate	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature										
Regis	trar	JUL 1 3 2010 Lenna	J. 1	backet									
DHMH 17 Rev 1/2	001	4	ORIGINA	L									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year ∬ÜÏÜ 11 201Ö Margaret Mary Brodowsky 12:30 A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore County Manor Care- Rossville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) JUIN 13 4 1922 1 M 2 T Durmore, PA 87 176 16 6359 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h Count Baltimore County 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 USA 5914 Shady Spring Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping-Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Sophia Carabeanes Andrew Sestack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5914 Shady Spring Avenue Baltimore, Maryland 21237 19a. Informant's Name/Relationship (Type, Print) 5914 Shady Spring Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once.

State

10a, State

Maryland

Director

Funeral

Completed by

Be

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Physician/

Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I

Maryland 21215-0036

Baltimore,

Registrar

Ph sician/ Medical Examiner

sician and burial-transit attending physician I for use as the buria requires that the death certificate be signed by the a d be detached fo been si should page 2 s his certificate h I director, page To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director,

P.0.

Division of Vital Records,

August Adam Brodowsky (Husband) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify Entonoment Gardens of Faith Cemetery July 13 2010 Baltimore, Maryland 21. gnatur of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsv perform Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

D0069314

8813 Waltham Woods Rd, Parkville MD

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

MD

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mittal Prayapat' 8813 Wall the

apati

10-05074 Leroy Bey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Leioy Dcy	1-For State Certificate of Death Reg. No. Reg. No.	21/2:								
Physician/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	3. Time of Death								
Medical Examiner	Leroy Bey July 6, 2010	2121 hrs								
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Union Memorial Hospital 4c. County of Death Baltimore									
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birth	nplace (State or								
Director	2/2-36-7230 1 M 2 F 7/ Yrs. Months Days Hours Min. 04-02-1939 Foreign Cou									
w any		10d. Inside City Limits								
Aaryland 28a-f show Lat once. ector	Maryland NIA Baltimore	1 Yes 2 No								
e Mary or 28a icd at	10e. Street and Number 10f. Zip Code 10g. Citizen of What Count 2759 The Alameda 21218 United Cfat									
r death with the Marylanc or items 23a or 28a-f sh must be motified at one Funeral Director	2759 The Alameda 2/2/8 Unified Start 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Start Status)									
death v r item nust b	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.									
s after ral", o	3 Widowed 4 Divorced If Yes, low Year 1 Yes 2 No specify: Specify: O a c									
hours hours Exam		dustry								
5-0036 ed within 72 hour 19 yogiene. other than "natu he Medical Exam	Laborer Construc	tion								
5-00 led will lygien other the M	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)									
21215-0036 Juld be filed within 7 I Mental Hygiene. marked other than it event, the Medical To Be Comple	Le vou M. Bey 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,									
O € 5 3 4 1 .	19a. Informant's Name/Relationship (Type, Print) Chavlane Bey-Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 1614 Barday St. Balfoy MO21	2 () ()								
ore, MIss I and 2 strains of Health a If item 27 her traum	20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or T	Town, State								
MOF Pages : ent of int: If nt: If	1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other Specify: Removal from State Metro Cromatory 7/15/2010 Baltonia	ND								
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Links Links Licensee 22. Name and Address of Facility Links Links Links Licensee	ica, P.M								
	270 Fired hi, Hon Pass Ba Has, MD 2 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval								
Physician /Medical	failure. List only one cause on each line.	Between Onset and Death								
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Typertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):									
_	Sequentially list conditions, b.									
nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c.									
ted Insit Examiner	events resulting in death) Last Due to (or as a consequence of):									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Exc										
60, ate be shysici ne buri	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery									
ox 687 eath certific attending p for use as th	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Da	ay Year								
he death certific. the death certific by the attending p ched for use as th	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown									
P.O. I s that the greed by the detache										
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safer death. The law requires that the safer death. The law requires that the safer death of th	1 Yes 2 ✓ No 3 Proba	opsy findings available								
Records, The law requires ficate has been signage 2 should be Completed	autopsy prior to comperior to c	ompletion of cause of								
tal Rection: The certificate ector, page	1 Yes 2 ✓ No 1 Yes	2 No								
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner? 1 About 1 Inpatient 2 ER/Outpatient 3 DOA Other, 1 About 2 About									
n of Vi ding Physi I. After this funeral dir	27 Manager of Death 29a Date of lower 28b Time of lower 19ac lower at Work 2 28d Describe how injury occurred									
ion teath. tor: A the fu	1 V Natural 5 Pending 1 Yes 2 No No Nestigation									
Division o spital or Attending nours after death. neral Director: Aft filled in by the function:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rura or Town, State)	al Route Number, City								
Di ospital hours a uneral I ly filled										
Division To the Hospital or Attent within 24 bours after death To the Funeral Director: completely filled in by the Medical Certificati	(Check only one) 2 Medical Examiner: On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.									
Me G G G	and manner stated. 29b. Signature and title of certifier 29d. Date signed (Mont	th, Day, Year)								
	July 7, 2010									
21	30. Name and address of person who completed cause of death (Item 23a)									
State	Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Regulars Signature									
State Registrar										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Frank Oliver Bunnel		rtment of Health and Mental I tificate of Death	Hygiene 2010 21726
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last) Frank Oliver	Bunnell Jr.	2. Date of Death Month Day Year July 8, 2010 3. Time of Death 0914 hrs
	4a. Facility Name (if not institution, give street and number) 8108 Longpoint Road	4b. City, Town, or Location of Dea Dundalk	th 4c. County of Death Baltimore County
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. late 213-70-2912 1 M 2 F	ast birthday) If Under 1 Year If Under 24H Months Days Hours M	Fassian
any	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location	10d. Inside City Limits
Maryland 28a-f show any d at once. ector	Maryland Baltimore	Dundalk 10f. Zip Code	1 Yes 2 No
the Maryland a or 28a-f sh tified at onc	8108 Longpoint Road	21222	USA
er death with , or items 23. r must be no	11. Marital Status 1 \(\overline{\chi} \) Never Married 2 \(\overline{\chi} \) Married Armed Forces? 1 \(\overline{\chi} \) Yes 2 \(\overline{\chi} \) No	S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	
rs after d	3 Widowed 4 Divorced of Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind o	Specify: White f work done 16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	itired)
d within ygiene.	12 years 17. Father's Name (First, Middle, Last)	Packaging 18. Mother's Nan	ARC of Baltimore ne (First, Middle, Maiden Surname)
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Frank Oliver Bunnell Sr. 19a. Informant's Name/Relationship (Type, Print)		n Bonsall Rural Route Number, City or Town, State, Zip Code)
MD 21 nd 2 should alth and Me nn 27 is ma aumatic ev	Frank O. Bunnell Sr. Father	8108 Longpoint Road,	Dundalk, Maryland 21222
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 V Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, rematory or other place) Juk Lawn Cemetery	Date 20c. Location - City or Town, State 2010 Dundalk, Maryland
Balti Permit. Departm Imports injury o	Other Control	22. Name and Address of Facility Connelly Funeral	Home Of Dundalk, P.A.
Physician	23á. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	Road, Dundalk, Md. 21222 or respiratory arrest, shock, or heart Approximate Interval Between Onset and
Examiner		nia Complicated by Hype	erthermia Death
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gauss (Disease or injury that initiated events resulting in death) Last		
0, e be executed rsician and burial - transit edical Ex	d	,28a-f per me g906 8-1	6-10 vt
ox 68760, eath certificate be execut attending physician and for use as the burial - tra rsician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregr	nancy 2 Fetal death 3 Ectopic pregi	23d. Date of delivery
). Box 6876 the death certificate by the attending phyched for use as the Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	ath 5 Other (Specify)	
cords, P.O. Box 6 aw requires that the death ore mas been signed by the attend 2 should be detached for use 1 pleted by Physicis	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown
Division of Vital Records, P.O. Box 68766 no the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/IM			24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ital Recician; The lician; The lician; The licians sertificate licetor, page	25. Was case referred to medical examiner?	26.Place of Death (Chec	k only one)
of Viting Physic ing Physic After this uneral director on: To 1	1 ✓ Yes 2 No Hospital: 1 Inpatient 2 2. 27. Manner of Death 28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 DOA Other Nurs 28b. Time of Injury 28c. Injury at Work?	ing Home 5 Residence 6 Other Scene 28d. Describe how injury occurred Subject expose
Sion Attendin death. Actor: A sy the fur catior	Natural 5 Pending 7-8-10 Pending Investigation	9:04 am 1 Yes 2 X No	to high environmental temperatur 28f. Location (Street and Number or Rural Route Number, City
Division of a Division of within 24 hours after death. To the Funeral Director: After templetely filled in by the funeral ledical Certification: Tedical Certification: T	Suicide Could not be determined (Specify)	me, farm, street, factory, office building, etc. sidence	8108 Longpoint Rd, Dundalk, M
To the Ho within 24 P To the Fur completely	(Check only Certifying Physician: To the best of my knowledge		at the time, date and place, and due to the cause(s)
Me s T s T	29b. Signature and Interest of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) July 9, 2010
8	30. Name and address of person who completed cause of death (Item Melissa Brassell, MD Assistant Medical Examin		21201
State	31. Date filed (Mogl. May, bay) 2010 32. Figistrar's Signatu		
Registrar DHMH 17 Rev 1/2001		ORIGINAL	

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 24a,b per np 9905 7-13-10 vt

State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM#23a,pt1,C905,7/20/2010,WS

Certificate of Death

Reg. No. 20 | 1 State
 Registrar Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ Annabelle Bevard 2010 5:30 P. ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center @ GBMC Towson 8. Date of Birth Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) Maryland Days 1 □ M 2 🔀 F Months Apr. 23, 1931 Hours Director 79 218-26-3155 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🙀 No Aberdeen Maryland Harford 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 901 Barnette Lane, Apt. 308 21001 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Completed 3 Widowed 4X Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Health Care 12 Secretary permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lucille Virginia Ward William (nmn) Bevard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1424 Rosewick Avenue, Baltimore, Maryland, 21237 Donna Cameron Oehm/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 7/10/10 Madonna, Maryland Presb. Cemetery Signature Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Inset and Death 2010 Immediate Cause (Final Ph_sician/ Corenzousauro disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: Atter this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an proposal autopsy performed? Yes 22N death? 1 ☐ Yes 2 🗷 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Frantioner: To the cost of my more age, death occurred at the time date and place, and due to the cause(s) and manner stated (Check only or 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OV 31. Date filed (Month Det. Year) State Registrar

State Registrar

DHMH 17 Rev 1/2001

9901 medical Center Drive Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Akimbely Tafolla, mo
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29d, perPHYS, G905, 7,19/2010 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 9, 2010 10:00 AM S Buas Panagiotis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 8807 Tuckerman Lane Potomac If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral 1 🔀 M 2 🗆 F Days (Month, Day, Year) Months Hours Min. Country) Albania Director 579-42-2624 82 April Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d, Inside City Limits aţ 10a. State with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 ☐ Yes 2 💢 No Maryland Potomac Montgomery 10f, Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 20854 8807 Tuckerman Lane United States death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Business Owner</u> <u>Hotel</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Spiros Buas <u>Vasilike Bevia</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Dena Buas/Wife 8807 Tuckerman Lane, Potomac, Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 12, 2010 | Silver Spring, Maryland Gate of Heaven Cemetery Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Lice S Horan 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician/ Myocardial Infarction Medical Due to (or as a consequence of Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Diabetes Mellitus Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension performed? Yes 2 X No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ne D34590 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 v Roy Fried, M.D. 7758 Wisconsin Avenue #211, Bethesda, Maryland 20814 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^Y July 6:00 а. м Rosiland Eileen Chandra Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death n/a Baltimore 523 Lyndhurst Street Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2💢 F Months Hours Min. (Month Day Year) 949 Director 212-48-9398 60 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director M∏ Yes 2 ☐ No Baltimore MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 523 Lyndhurst Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No Yes Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: African-American 3 Widowed 4 Divorced Completed or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Property Manager Oxford Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Olif L. Tillett James Gross Sr. 19a. Informant's Name/Relationship (Type, Print)
Darlene White/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 Lyndhurst Street, Baltimore, MD 21229 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 7-17-2010 Baltimore, MD Donation 5 D Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Imme late Cause (Final Onset and Death Physician/ monan disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and abe detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 1 onths? Month Day Year Pregnant at time of death No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Yes 2 No 3 Probably 4 Unknown this certificate has been si ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed' 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 船 26. Place of Death (Check only one) examiner? ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29c. License number E address of person who completed cause of death (Item 23a) (Type, Print) MDalaco 32. Registra State

DHMH 17 Rev 7/2009

Registrar

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any hiury or other traumatic event, the Musonce.

Physician

/Medical

Examiner

10a. State

MI

Director

Funeral

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Completed

Be မ

Funeral

Director

ir than "natural", or items 23a or 28a-f show

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

sician and burial-trans the Hospital or Attending Physician: The law requires that the death certificate be execut Division of Vital Records, P.O. Box 68760 e attending prover ned by the a page 2 s

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

231. Par 1. Enter the disease, or cor spock, or heart failure. List on	nplications that caused the death. Do not enterly one cause on each the.	the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death				
Infraediate Cause (Final disease or condition	SEPSIS			Onset and Death				
resulting in death)	Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate	b. ASPIRATION F Due to (or as a consequence of):	PNEUMONIA						
cause. Enter Underlying Cause (Disease or injury	- TOTAL TOTAL	11.4						
that initiated events resulting in death) Last	c. Due to (or as a consequence of):	17						
	HYPOGLYCEMIA	7-4						
Jean Heading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last JEFEMALE: 23b. Was decedent pregnant in the past 12 months? 1		ictopic pregnancy other (specify)	2	3d. Date of delivery Month Day Year				
Part II. Other significant conditions	contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?				
END SMAE	RENAL DISEASE		1 ☐ Yes 2 ☐	No 3☐ Probably 4XUnknown				
LIVER FAILU	RE		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ★No				
25. Was case referred to medical		26. Place of Death		T Yes Z No				
examiner? 1 ☐ Yes 2 ★No	Hospital: 1 Inpatient 2 ER/Outpatient	Othori	e 5 ☐ Residence 6	Other (Specify)				
27. Manner of Death 1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not 4 Homicide determined		28d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		t, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 Certifying F (Check only 2 Medical Exe	hysician: To the best of my knowledge, death o minor: In the basis of examination and/or invertal date of manner stated.	occurred at the time, date and place, a stigation, in my opinion, death occurre	nd due to the cause(s) d at the time, date and	and manner as stated. place, and due to the cause(s)				
29b. Signature and the contriler	411	29c. License number	29d. Date	signed (Month, Day, Year)				
D 1717	W HAD	D0060293	TUL	4 8 2010				

DHMH 17 Rev 1/2001

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State Registrar 30. Name and address of

MURTUZA

31. Date filed (Month, Day,

OLD COURT ROAD RANDAUSTONN MD 21133

To complete cause of death (Item 23a) (Type, Print)

AUMED, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) **Physician** 2010 9:17 A^{M} Dorothy E. Cornell July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cecil Elkton Care and Rehabilitation Ctr. E1kton 8. Date of Birth (Month, Day, You April 13, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Hours Min. Days 1 □ M 2 🕏 F April 1923 Maryland 221-10-9269 87 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, Its Modical Examiner must be notified at 1 ☐ Yes 2 No Director MD Cecil E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2254 E. Old Philadelphia Road 21921 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must. once. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: ₽ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) own home housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Millard Fillmore Ritchie Blanche Irene Grant 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Gary Smith - nephew 1101 E. 6th Street; Austin Texas 78702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funday Service Licensee Nay1 22. Name and Address of Facility Board; 655 W. Baltimore Street kenn Baltimore, Maryland 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) **Physician** 200 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequen P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an conce certificate has breactor, page 2 sl autopsy performed Yes 2 Division of Vital 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 ☐ Pending investigation after death.

I Director: Aid in by the fu 1 ☐Yes 2 ☐ No 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifler Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier 29b. Signal 20 D0060756 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who loin St. SIE C 31. Date tiled (Month, Day Year) ~ (D) 32 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NADA GERTRUDE Month CARVER-POLAN Year **Physician** Õ 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** timose Franklin 7. Age (In yrs. last birthday) Koseda 00 a was If Under 1 Year | If Under 24 Hrs. 5. Social Security Number A Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 09/30/1934 1 □ M 21 F 75 W. VIRGINIA Director 233-48-1898 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it is free to other traumatic event, it is fred in any injury or other traumatic event, it is fredien Examinant to norflind at Director MD BALTIMORE 1 ☐ Yes 2 No **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8620 KELSO DRIVE APT C 210 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTING 12 SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DOY OSCAR SKINNER IDA BLANCHE REED ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ORAL J. POLAN III/SON 292 STILLWATER ROAD BALTIMORE, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL CEM 7/13/10 MIDDLE RIVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ser 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME CHESACO AVE BALTIMORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sevese disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tons Sequentially list conditions, if any 1-2 fing 1, in Todal cause. Enter Underlying Cause (Disease or injury that initiated events Examiner consequence of fa physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown DI 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy DM 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1☐Yes 2☑No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.O. I of Vital Records, Division

 $A\mathcal{R}\mathcal{V}\mathcal{L}\mathcal{L}$, $\mathcal{N}\mathcal{R}\mathcal{D}\mathcal{A}$ timore, Maryland 21215-0036

altimore,

attending p signed by the a d be detached for peen cate has t director, page To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p.

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

9000

29c. License number 369 D005

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 21734 Frances Lee Conners State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month **Medical Examiner** 1000 hrs July 5, 2010 Frances L. Conners 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2627 Frederick Avenue Baltimore 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 217-92-8835 1 M 2 X F 39 Yrs Oct. 7,1970 Country Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show : e notified at once. 1 Y Yes 2 No MD. Baltimore imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 514 Brunswick St 21223 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 Married 2 X No Yes Specify: White 4 X Divorced If Yes, Give Year 1 Yes 2 No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Disable Disable 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) æ William Francis Bernadette Vogt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8812 Fort Smallwood RD. Pasadena, MD. 21122 Janice M. Terry - Sister 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place)
Loudon Park Cemetery July 9,2010Baltimore, Maryland 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AMBROSE FUNAERL HOME, INC. 328 Sulphurs Spring RD. Arbutus, MD. Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Merdical Death Narcotic (morphine) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical this certificate has been signed by the attending physician a I director, page 2 should be detached for use as the burial -AMENDED 23a,27,28a-f,per ME G905 7/22/10 TT XUNPENDED To the Hospital or Attending Physician: The law requires that the death certificate be evident 24 hours after death.

To the Funeral Director: After this certificate has been account. Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Month Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Investigation 1 Yes 2 X No Director: d in by the f Fd 9:49 am Fd 7/5/10 Accident completely filled in by 28f. Location (Street and Number or Rusal Route Number, City or Town State) 2027 Frederick Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide altimore, determined (Specify) found at home 4 Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 6, 2010 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

ORIGINAL

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Year Dolores Frances Crane JUIV 11 2010 3:10 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Days Min. 218 28 0280 78 Yrs March 9 1932 Baltimore City, MD **Director** Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5828 East Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", White 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leola F Bensel Edward W Scoone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8805 A Chandler Drive Surfside Beach, S.C. 29575 Nancy Bentz (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Cemetery July 13 2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home, Inc. 4 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ Chionic gostroffice nononia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year been signed by the should be detached 1 ☐ Yes 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: perform rmeg? No 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No Hospital 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 8, 2010 Genevieve Mae 23:05 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George . Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 1 F Months Days May 28, 1918 577 18 2827 Washington DC 92 Director Usual Residence of Deceden and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at **Funeral Director** 1 Yes 2 No Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 2507 Boones Lane 20747 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give XX No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ₩Widowed 4 □ Divorced Specify. Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the 9th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 UNKNOWN 7 is marke traumatic Elmore UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty C. Joubert (Daughter) 12319 Manvel Lane, Bowie, MD 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If any injury or once. Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) July 13, 2010 Suitland, MD 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria m 1)a Ferry Road, Clinton, MD Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner aron ON Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of signed by the attending physician and it is detached for use as the burial-transit Exam Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna☐ Other (specify) Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 🗌 Yes 2**X** No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: Manner of Death ie Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) within 2 Fertiving Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0004270 Name and address of person who completed cause of death (Item 23a) (Type, Print) NW Suite 314 Washington, D.C. 20037 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Martha Sullivan Downey 2010 July 10. 5:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Augsburg Lutheran Home Baltimore Baltimore County Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Zihlman, Maryland (Month, Day, Year)
Jan. 05, 1918 1 □ M 2 🔀 F Months Davs Hours Min 214-07-3337 Director 92 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a State 10b County 10c. City. Town or Location 10d Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore County Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Campfield Road items 23a Funeral 21207 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White "natural", 3X Widowed 4 ☐ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha the Office 12 Secretary N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Jerome Sullivan Lydia Eisel 19a. Informant's Name/Relationship (Type, Print Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Mrs. Elizabeth D. Lopez Baltimore, Maryland 408 Woodford Road 21212 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel and (Harford Co.) -13-2010 4 Donation 5 Other (Specify) Forest Hill, Maryland Cremetion Services, Inc. 21. Signature of Funeral Service Acenses Jeffrey L. 22. Name and Address of Facility
Reaceful Alternatives Funeral & Cremation Center, P.A. Gair, Sr. Timonium, Maryland 2325 York Road 23a. Pay 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear rialiure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ e&/> disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Vear Pregnant at time of death as been signed by the 2 should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 dep (Ap 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autonsv page death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ♣No Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending Accident after death. Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined building, etc. (Specify) City or Town, State) 24 hours a Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of certifier 29c. License number D37573 12,2010

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed ca

Shell

MD

21207

ath (Item 23a) (Type, Print)

5835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Thomas Doll Sr. 2010 10:07 P M 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Middle River 6911 Yale Rd. Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F Davs Months Hours Min. 219 12 8455 Maryland 85 Director Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Middle River 1 ☐ Yes 2 🄀 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21220 6911 Yale Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Completed by Yes 2 f Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 Year or Dates. WW II 1 ☐ Yes 2 ☑ No Specify: Hygiene. other than "natural", Specify: White 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Instructor and Mental Hygien is marked other t 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is meany injury or other? ပ Charles Doll Caroline Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Doll (Son) 2045 Mardig Dr. Forest Hill, Maryland 21050 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Holly Hill Mem. Garden's 7/14/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin asu Cause (Disease or linjury that initiated events burial-tran resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy □ Live Birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No has certificate 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred the Hospital or Attending X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 ed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eunice Beatrice Deimel 1:06 AM WILL 121 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Princé George's Lanham Doctors Hospital 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XX F Months Days Hours Min. Dec 19 Day 1942 Washington DC 67 216 40 8015 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20746 4606 Lacy Ave United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Was Decedent Armed Forces?

1 ☐ Yes 2 ▼ No Black, White, etc. þ 1XX Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 TNo Specify. White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Nurse R.N. Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph A Deimel မှ Pearl Eunice Eaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 True Street #403, Columbia S.C. 29209 William P. Castronuovo (Cousin) Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place July 12,2010 Suitland, MD 4 Donation 5 Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Lee Funeral Hone, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 20 moo257 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coverage

Due to (or as a consequence of) artery disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last **To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. Denpherel attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 1 per ten Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available pnor to completion of cause of death? 24a. Was an autopsy performed' 24 hours after death.
Funeral Director: After this certificate teed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မှ 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Arem 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 ROAD 32. Registor's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day _Year Kent Zia Erman 9:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Joseph Medical Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 🛛 M 2 🗆 F Min. June 20 214-84-6026 52 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Baltimore Baltimore City txxYes 2 ☐ No 10e. Street and Number 10f. Zip Code United States of America Funeral 21224 3324 Fleet Street Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2 No Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Completed 3 Widowed 4 Divorced white Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. IMEX Enterprises Sales Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna May Meyett Hassan R. Erman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 Page 1 and 2 street of Health a tant: If item 27 is Mr. Rifat H. Erman/ brother 10205 H Sunnylake Place Cockeysville, Maryland 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of It
Important: If ite
any injury or ot Evans Funeral 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 2010 4 Donation 5 Other (Specify) Forest Hill, Maryland Bel Air 21. Signature of Funeral Service License Peaceful Alternatives Funeral & Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ISCHEMIC ENCEPHALOPATHY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner VENTRICULAR Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury SUBARACHNOID HEMORRHAGE that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an performed Yes 2 of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at M Natural 5 Pending Division 24 hours after death. Funeral Director: A 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital o within 24 hours af To the Funeral Di completed filled ir Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Jarks

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ J_{uly}^{Month} Gloria Marina Echeverria 2010 9 11:40 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, August 12 6. Sex **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🛣 I Days Hours 577-84-5278 64 Guatemala Director 1945 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at 10d, Inside City Limits Director Maryland | Montgomery 1 ☐ Yes 2 🛣 No Rockville 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5013 Randolph Road 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian "natural", or þ 1 Never Married 2 X Married 1 Yes 21 If Yes, Give Year or Dates. 2K No Baltimore, Maryland 21215-0036 1x Yes 2 □ No Specify: Guatemalan Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be Reginaldo Garcia Rosa Castillo Echeverria 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5013 Randolph Road, Rockville, Maryland 20852 Manuel de Jesus Echeverria/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July Date 13. Gatemetery, crematory or other place)
Gatemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Silver Spring, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Nockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 Signature of Funeral Service License M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) End Stage Liver Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has boom about the continuate has been approximated. that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 X No Month Year sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Septicemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Cerebrovascular Accident 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospice Inpatient 1 ☐ Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 \square Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗵 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 10, 2010 CRA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Diane Ruckert,

132010

31. Date filed (Month, Day, Year)

CRNP

Rockville, Maryland 20855

6001 Muncaster Mill Road,

32. Registrar's Signature

		For State Registrar	State of M	laryiand				Mental Hy	_	2010	217	42
Physician		Decedent's Name (First, Middle, Dorrea)	_{Last)} ha Foster							10	3. Time of D	Death M
Medica Examine		4a. Facility Name (if not institution, 7312 Fairbrook Ro							4c	. County of Do		-
Funeral Director							If Under 24 Hrs		rth ay, Year)	9.1	Birthplace (State or	Foreign
and show	tor	Usual Residence of Decedent 10a. State 10b. County		4b. City, Town, or Location of Death Windsor Mill 7. Age (In yrs. last birthday) 63 Yrs. 10c. City, Town or Location Windsor Mill 10f. Zip Code 212/44 10f. Zip Code 216/44				/ Limits				
the Maryl or 28a-f e notified	Funeral Director	MD Bal	imore		Windsor				10g. Ci	tizen of What		inside City Limits Inside City Limits I Ves 2 No Indian, American y Dispital
ath with ems 23a r must b	unera	7312 Fairbrook Road	·	Ever in U.S				pecify Yes or No-	.	USA	merican Indian,	
ırs after de ıral", or itu Examine	þ	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces?			f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		Black, W	hite, etc.	erican
nin 72 hou ne. han "nath e Medica	Completed	15. Deceden (Specify only higher Elementary/Seconday (0-12)	's Education t grade completed) College (1-4 or	5+)	(Give life. D	kind of work done o O NOT use retired)		orking	1	ind of Busine		
Hyg othe	To Be C	11th 17. Father's Name (First, Middle, Li Robert Norton	lst)		House	keeper			, Maiden		tan Hospita	ıl
2 should Ith and Me 27 is mar traumati		19a. Informant's Name/Relationsh Sandra Patterson/ Da					and Number or R	ural Route Numbe	er, City or		Zip Code)	
Page 1 and lent of Hea nt: If item ry or other		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)	3 ☐ Removal from State	. I ce	ace of Dispo	sition (Name of	re)	Date	20c. L		or Town, State	
permit. P Departm Importa any inju		21. Sign Jure of Funeral Service Li		10							Balto. Co.	
Physician/ Medical Examiner		23a. Fart 1. Enter the disease, or chock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	lly one cause on eagh lin	e., a	tion T					Λ		/een
be eg	dical Examiner	Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c	b. Due to (or as a consequence of): Due to (or as a consequence of): d.								
the attending physiched for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	sy			23d. Date of Month	-	ear
requires that the desbeen signed by the should be detached	چ ا									acco use contribute to the cause of death?		
ite has been age 2 shou	Completed							24a. Was auto perfe 1 \(\text{Yes} \)	psy ormed?	prior death	autopsy findings av to completion of ca of? Yes 2 X No	
certifica irector, p	Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital:	·		Oth	ace of Death (Che	eck only one)				,
within 24 hours after death. To the Funeral Director: After this certificate ha	Certificate: To	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)										
Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. Funeral Director: After this certificate has been signed by the attending physted filled in by the funeral director, page 2 should be detached for use as the		4 ☐ Homicide determi 29a. Certifier 1 ☐ Certifying	building, et		Hon		, date and place,	#2A, W	ands	i,m70	11, MO,21;	249
To the Ho within 24 P To the Fur completed	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of e Nurse Practioner: To the	examination	and/or invest	igation, in my opinio	on, death occurred e time, date and p	at the time, date:	and place ne cause(e, and due to the s) and manner	ne cause(s) and man	ner stated.
		30. Name and address of person w	ho completed cause of c	death (Item	23a) (Type, F	rint)	3667		Ju	412.	2010	
State	е	31. Date filed (Month Paye Year)	Pello MD	ar's Signatu	rimbl	eH:11(T. Luth	erville	3 1	19 5	1093	

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# 2per PHYS, G905, 7/15/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death
Month 09
July 7 ^{Day} 2010 Physician/ Year Earl R. Fletcher 9:03 Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 8226 Selwin Court Rosedale Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Dec. 19 1 🛛 M 2 🗆 F Months Hours Min. Year) 1922 New Jersey 141-18-7566 87 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Rosedale 1 Yes 2 XNo 10e Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral with items 23a 8226 Selwin Court 21237 USA death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) General Motors Oiler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Frederick S. Fletcher Elizabeth R. Dewar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Wols-daughter 8226 Selwin Court-Rosedale, Maryland 21237 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Greenwood Cemetery July 13,2010 Hamilton, New Jersey 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

Evan's Funeral Chapel and Cre
8800 Harford Road-Parkville

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition) s^{and}Address of ^{Facilia}thapel and Cremation Services Harford Road-Parkville, Maryland 21234 Approximate Interval Betweer Onset and Death 10 Months Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the thoract director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Yea Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 🏋 No 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year) D59359 July 9, 2010

State Registrar

h

Raymond H. Zollinger M.D. 4924 Campbell Blvd. Ste. 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Baltimore,

MD 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10c of perFH, 6905, 7/30/2010, WS
State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 10°, 2010 12:12AM Catherine E. Fallon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Holly Hill Manor Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F 218-26-3378 80 Months Days Hours Min. Month, Day, June 3, 1930 **Director** Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Parkville 1 ☐ Yes 2 🔀 No Towson 10e Street and Number 531 Stevenson Lane 5524 Oak Leigh Road 10g. Citizen of What Country? Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XX 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Housewife At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margareth Scheihing James Gallagher 19a. Informant's Name/Relationship (Type, Print)
Catherine Butanis (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2820 Glen Keld Court Baldwin, Maryland 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park 20c. Location - City or Town, State Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State July 14, 2010 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. Let only one cause on each line.

Immediate CauseVFnal disease or condition are caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate CauseVFnal disease or condition are caused to the death. & Cremation Services—Parkville kville, Maryland 21234 Approximate Interval Between Onset and Death Physician/ preumenia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd touk M ork 31. Date filed (Month, Day, Year) 32. Registra State 132010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Finch Η. 1900PM Warren Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MOSPITAL DALTIMUR TIMORE 8. Date of Birth (Month, Day, Year)
11 04 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 ▼ M 2 🗆 F Months Days Hours Min. Director 217-18-9031 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other trainment. oortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21207 3707 Bowers Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Narried 1 Tes 2 No Specify: If Yes, Give Year or Dates 3 🗆 Widowed 4 🗆 Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12)
12th grade College (1-4 or 5+) Mail Carrier Post Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Agnew Finch <u>Laura Curtis</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Finch-Wife
20a. Method of Disposition 3707 Bowers Ave, Baltimore, Md 21207 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 7/19/10 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Ihom 4300 Wabash Ave, Baltimore, Md Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part shock, or heart faild Immediate Jause (Final heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ disease or condition resulting in death) mond Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): inding physician and use as the burial-tran that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be execu Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 1 Yes 2 9 Unknown s been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? and. 1 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed After this certificate 2 4 No 1 Tes Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 1 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation within 24 hours after death

To the Funeral Director,
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANDER Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

Z/A

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

filed withir Hygiene.

of Health

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

DR. NAVEEN VOORE

31. Date filed (Month, Day, Year)

RES 0000

9000 FRANKLIN SQUARE DR. BALTIMORE, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 9:05P M July 11, Chambers Fort Elizabeth 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Broadmead Cockeysville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 27,1933 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🖾 F Months Days Hours Min. 244-44-2501 Kentucky Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 1 ☐Yes 2 No Phoenix Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21131 USA 2418 Stanwick Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home 02 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Schuyler Chambers Etta Wheeler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2418 Stanwick Road, Phoenix, Maryland Archibald Taylor Fort/Husband 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 T Cremation 3 ☐ Removal from State 15 ☐ Other (Specify) 7/13/10 4 Donation Atlantic Crematory Glen Burnie, Maryland Bryan W. 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. Clary 10 W. Padonia Road, Timonium, MD 21093 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part . Enter the disease, or co-sheck, or heart failure. List on Approximate Interval Between Onset and Death Immedi te Caur (Final disease o ndition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4 Pregnant et time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 🕡 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1□ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

with

ral", or items 23a or 28a-f shov Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, It e Machell Examination on one.

Baltimore, Maryland 21215-0036

Funeral Director

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Completed

Be

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burial-transi attending physician for use as the buria

Box 68760.

P.0.

Division of Vital Records,

Physician/Medical Examiner

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Completed

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Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate nis certificate has been signed by the director, page 2 should be detached After this after death filled in by the

within 24 hours a To the Funeral D State

Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29b. Signature and title of certifier

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

27. Mann of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

6 □ Could not be

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Maryland		artmen <i>tificate</i>			and M		gien Reg. N	711111		21748	
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Robert Lewis Franklin								2. Date of Death Month July 9, 2010 3. Time of Death 7:20 AM					
	Medic Examin	al									4c. County of Death					
	Funeral Director		5. Social Security Number 218-70-8758	6. Sex. 7.	Age (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da NOV		9. Bir	thplac untry)	e (State or Foreign rland	
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. Count MD	у		Town or Loc								10d.	Inside City Limits 1 ✓ Yes 2 □ No	
	th the Ma 3a or 28 t be noti		10e. Street and Number			ar criic	10f. Zip				T	10g. C	itizen of What Co		?	
	death wi items 2 ner mus		3333 Elm Ave	12. Was Decede	nt Ever in U.S.	13. V		2121 ent of His ifv Cubar	spanic Orig	gin? (Spec	cify Yes or No-		United	erican	Indian,	
0036	ours after tural", or	eted by	1 Never Married 2 ☐ Mi 3 ☐ Widowed 4 ☐ Divorce	arried 1 Yes 2 If Yes, Give Year or Dates	□ NO 5.1974/7	17 1	☐ Yes	2 No	Specify:		,		Black, Whit Specify:	W	hite	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed	(Specify only high Elementary/Seconday (0-12)	ent's Education hest grade completed) College (1-4 of		life. DO	lent's Usua kind of wor D NOT use chani	k done d retired)		t of workir	g	16b.	Kind of Business Carpeti:		try	
/Jand	d be filed v Aental Hyg arked othe	To Be	17. Father's Name (First, Middle Earl Reubin	•	! -						(First, Middle, Jean Wh		Surname)			
	1 and 2 should of Health and N item 27 is ma rother trauma		19a. Informant's Name/Relation Shirley Ste	ship <i>(Type, Print)</i> ncil /Domesti	.c Partn								or Town, State, Zi	ip Cod	e)	
Baltimore,	Page nent ant: It		20a. Method of Disposition 1 Burial 2 Crematio 4 Donation 5 Other	n 3 Removal from Sta	ate cen	ce of Dispos netery, crem	natory or o	ther place			Jul 10 2010	20c.	Location - City or Beltsvil		, State Maryland	
Balt	permit. Departn Imports any inju		21. Signature of Funeral Service	Hocher	Moisq	35 22					ral Alt		atives wson Mary	/lar	nd 21286	
1	Physician/ Medical		23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	only one cause on each	sed the death. line.	^	er the mode	of dying	g, such as	cardiac or	respiratory ar	rest,		In O	pproximate terval Between nset and Death Months	
	Examiner	<u>.</u>	Sequentially list conditions,	Due to (or	as a consequer	nce of):										
اب عق =	and -transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Usecuse (Usecase or injury that initiated events resulting in death) Last	С.	as a consequer											
092	ate be executed physician and the burial-transit		resulting in death) East	d												
7/9/0 . Box 687	Attending Physician: The law requires that the death certificat or death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 I Fetal on that time of dea	death 3	Ectopic p Other (sp		у				23d. Date of de Month	eliv e ry Da	y Year	
رّم ds, P.O	law requires that the de has been signed by the a e 2 should be detached	by	Part II. Other significant condi	tions contributing to deat	h but not result	ting in the u	nderlying o	ause giv	en in Part	l.			use contribute to		eause of death?	
Franklin I Records,	24a. Was an autopsy performed? 1 Yes 2 2 2 2 2 2 2 2 2 2								24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No							
CO.	sician: certific irector,	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2* No	Hospital:				Otho	ice of Dea					.1	1 Al>	
Robaution of Vita	nding Physath. ": After this e funeral di	icate: To	27. Manner of Death 1 Natural 5 Pend	28a. Date of i	patient 2 Effinjury Day, Year)	R/Outpatien 8b. Time of injury		Bc. Injury work	4 ∐ Nu	2	ne 5 Resident		6XOther (Spec iry occurred	cify)	8/1C+	
27. Manner of Death 1										ural Ro	oute Number,					
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page.	Medical	(Check 2 Medical only one) 3 Certifyi	ng Physician: To the best Examiner: On the basis on g Nurse Practioner: To	of examination a	and/or invest	igation, in r leath occur	ny opinio red at the	n, death oo time, date	ccurred at	the time, date a	and plac	e, and due to the	cause	(s) and manner stated. d.	
	To to To to		29b. Signature and title of certifi	1					number 290	}-)			ate signed (Mont		, Year)	
141_			30. Name and address of perso	MANHETT	821	NEU	rint) TAN				BALTI	M	OLE L	11	21201	
lot !	Stat Registra		31. Date filed (Month, Day, Year)	Seren 32. Regi	istrar's Signatur	we !										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2010 5.35 M Shadai Guinn 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1timore Ose dale uase Pita If Under 24 Hrs. 8. Date of Birth
Hours 02 July 6, 2010 9. Birthplace (State or Foreign County)
Maryland If Under 1 Year 5. Social Security Number Age (In yrs. last birthday, Months Days 1 □ M 2 🕏 F INFANT Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1302 Sugarwood Circle 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2½ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Specify: black 1 ☐Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) INFANT College (1-4or 5+) INFANT INFANT INFANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shanara Guinn Lee Guinn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1302 Sugarwood Circle Unit 23; Baltimore, MD 21221 19a. Informant's Name/Relationship (Type. Print) Shanara Guinn - mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 21. Signature of Funcial Service Licensee Nay 191 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of). Immediate Cause (Final how disease or condition resulting in death) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical **Examiner**

and

attending physician

been signed by the should be detach

has

funeral director,

filled in by the

Hospital or Attending Physician: The 24 hours after death.

Funeral Director: After this certificate h.

within 24 hours a

To the Funeral

the

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, me Medical Evanings must be nydified at

12 should be fill the and Mental H

Health a

Injury or other permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other

Maryland 21215-0036

Baltimore.

Sequestibility list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe

23e. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner' 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

1 Inpatient 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

31. Date filed (Mont)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

6 Could not be determined

DOC63050

leside Rd Fallston,

29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) matt 500 Ana 1602

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
PATRICIA 2. Date of Death RAE GEISENDAFFER ^{Day} 2010 Physician/ $\mathbf{JULY}^{\mathsf{Month}}$ 9:49 PM 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE STELLA MARIS HOSPICE CENTER TIMONIUM If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-32-3079 1 □ M 2 🔀 F 74 4 Mosth, Pay 13 8 MARYLAND **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HARFORD BEL AIR MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21014 207 GLENWOOD ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 XMarried 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify: "natural", 3 Divorced 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname)
ROSALIE (CHASE) 17. Father's Name (First, Middle, Last) **JESSE** NELSON GRAYBILL 19a. Informant's Name/Relationship *(Type, Print)* HUSBAND RICHARD W. GEISENDAFFER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEL AIR, 207 GLENWOOD ROAD 21014 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛣 Burial 2 □ Cremation 3 □ Removal from State SACRED HEART JESUS 7-12-10 DUNDALK, MD 4 ☐ Donation 5 ☐ Other (Specify) e Licensee 22. Name and Address of Facility CVACH/ROSEDALE 1211 CHESACO AVE ROSEDALE, FUNERAL HOME MD 21237 Signature Full III 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence of the Examine Due to (or as a consequence of): s been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has be completed filled in by the funeral director, page 2 s autopsy Hospital or Attending Physician; The 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 27 Hospital: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and to 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) MD 21093

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G905, 7/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registra Reg. No 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ July 9, Year Gardner 2010 Jane West 9:43 p.mw Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 WY 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 💢 F 0370471918 Director 92 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 No MD Rockville Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 United States 303 Adclare Rd. hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc. Armed Force Yes 2 No Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 5+ Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel E. West Mabel Clevenger West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau / Daughter Mary Gardner Taylor 3214 Holdridge Rd. Silver Spring MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Chesapeake Crematory £07/13/2010 Beltsville, Maryland 4 Donation 5 Other (Specify) Signature of Juneral Service Licensee 22. Name and Address of FacilityRapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Advanced Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last nding physician ause as the burial-Physician/Medical requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No atter for u Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Parkinson's Disease page 2 s Hospital or Attending Physician: The law autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work 5 Pending 1 Yes 2 🗌 No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛮 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) rama D61382 07/12/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14816 Physicians Lane, Suite 152, Rockville, MD. 20850 M.D.Shama R. Mittal, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c&22, perFH, G905, 7/28/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month P^{M} Mary R. Holt June 23 2010 5:38 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1334 West Lafayette Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Jan 26, 19 Birthplace (State or Foreign Country) unk **Funeral** Months Days 1 □ M 2 🗓 F Hours Min. Director 219-26-7918 72 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Experience rest be notified at Director 1X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21217 1334 West Lafayette Avenue 72 hours after death Funeral unk 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Nunk 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ⊠No black If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk s 1 and 2 should be filed wi if Health and Mental Hygien item 27 Is marked other th ŭnk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Officer Leeks Baltimore City Police Dept 1034 North Mount Street; Baltimore, Maryland 21217 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4□Donation 5□Other (Specify)in state Metro Baltimore, MD 7/28/10 21. Signature of Finer I Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due Jor as a consequence of) Examiner equentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine and burial-tra Due to (or as a consequence of) Box 68760. attending physician for use as the buria law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) signed by the a Ö ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>۾</u> 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? certificate 2 46 1 □ Yes 2 🗆 NO 1 ☐ Yes of Vital Hospital or Attending Physician: 25. Was case referred to me ical examiner? funeral director, Be 26. Place of Death (Check only Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 □ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Kesidence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division To the Hosping.
within 24 hours after death.

To the Funeral Director: Aft

"maletely filled in by the fur-5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who complet cau e of death (Item 23a) (Type, Print) marsh 32. Registra's Signature 31. Date filed (Month, Day, Ye Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yea Month **Physician** 1:580 M HOOS 2010 barbara 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner anare Hos Center Baltimore Kosedale pital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 81 Yrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 214-26-9170 12/19/1928 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE NOTTINGHAM 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with ò 7928 BELRIDGE ROAD APT G 21236 USA 23a death \ Funeral items : Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 9 1 ☐ Yes 2 🛣 No Specify Specify: WHITE 2 3 ₩ Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATION SILVER TOP 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be JAMES HEJL ပ SOPHIE KOMIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any Injury or other trau MICHELLE EVANS/DAUGHTER 7405 GOETTNER RD KINGSVILLE, MD 21087 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 7/14/10 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Ricensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Lschemic disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed sician and burial-trans Inticoag Due to (or as a con, equence of P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 1/2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of c ted cause of death (Item 23a) (Type, Print) Drive, Bathmore al Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#9,11,12,15-20c,22perFH,G905,7/13/2010,WS
State of Maryland / Department of Health and Mental Hygiere 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician 1324 2010 William Harding June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** maryland General Hospital Baltimore 17 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number B. Date of Birth

[Month Day, 1948]

Jan 21, 1948 Birthplace (State or Foreign Country 117) **Funeral** Hours Min. 1⊠M 2□F 62 Yrs. 218-44-3980 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f ehov the Medical Examiner must be notified at Baltimore 1 Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 USA 501 West Franklin Street Race - American Indian, Black, White, etc. 11. Marital Status unlt 1X Never Married 2 Married Specify: black Baltimore, Maryland 21215-0036 δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mentel Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Building** Construction 18. Mother's Name (First, Middle, Maiden Surname) 411 17. Father's Name (First, Middle, Last) Unit-Woodrow Harding Alton Ricks 19a. Informant's Name/Relationship (Type, Print)
Ruth Joyner-El-1Sister
Haryland General Hoopital 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4004 Raymonn Ave. Baltimore, MD 21213
827 Linden Avenue, Baltimore, Maryland 212 partment of Heelth a sortant: If Item 27 te 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/0/19/1/1/2 4 □Donation SEOther (Specify) in State . March Funeral Home 21. Signature of Euneral Service Licensee Gary P. March Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ingu (ticiency Physician Aortic 2 mo /Medical Due to (or as a consequence of): Examiner In Get Live Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an anemia autopsy performed? Yes 22No 1 ☐ Yes within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6.29-10 1743386 WED 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 871 N. Bita 8405 Balto. Ho mand NO 31. Date filed (Month, Day, Year) 32. Registrer's Signature State 132010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of 3. Time of Death Month HiaGINS Physician/ Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northwest Hospice 2andallotown 9. Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral (Month, Day, 1 M 2 X F Months Hours T9 213.30.676 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10h County 10a, State Director Baltimore Windsor 1 Yes 2 XNo 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21244 Funeral 3413 Maryvale USA Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) Ft. Meade Supervisor N Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Eldera Hinton Norman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Koad Windson Mill, ND 21244 Unrola F. MCC 3413 Man MIECE! Nale 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Pikesville, ND 01/10/10 4 ☐ Donation 5 ☐ Other (Specify) Vallan C. Gileene Funtral Services 21. Signature of Funeral Service Licensee Road Randallstown MD 21133 Vau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or leart failure. List only one cause on each line.

Immediate Cause (Einal Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JÜLY 6:45A ™ 2010 Ralph J. Hoen, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson The Presbyterian Home
Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Hours Min. (Month, Day, Year) 05/30/1917 1 X M 2 □ F **Director** Pennsylvania 216-05-2093 93 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County with the Maryland Director must be notified 1 Yes 2X No MD Berlin Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be n Funeral 6976 Hall Drive <u> 21811</u> $U_{\bullet}S_{\bullet}A$ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 ☐
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates. WW II permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Aircraft Industry Purchasing Agent Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ralph J. Hoen, Sr. Mabel Stanton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Hoen (Grandson) 11907 Peyton Court - Bishopville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stephen Church Cem. 07/12/2010 Bradshaw, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. S) 11750 Belair Road - Kingsville, Maryland a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Theumon a disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner (pars emen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death Yes 4 ☐ Pregnant a 9 ☐ Unknown page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performed? 1 Yes 2 No After this certificate funeral director, pag Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🖼 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident ☐ Suicide Investigation in 24 hour.
the Funeral Directory filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fund completed it Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 037016 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 67 N. (Garle) St. Sate 4104, Kerneth M. Green. no

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

24174

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death William K. Harris, Jr. Yaiy 7, 2010 2:40 P. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall St. Mary's Charlotte Hall Veterans Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Months Days 1 XM 2 🗆 Hours March 7, 1921 Mary land 89 216-16-8060 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits St. Mary's Yes 2 No Maryland Charlotte Hall 10e. Street and Number Charlotte Hall Veterans Home 10f. Zip Code 10a, Citizen of What Country? 20622 LISA 29449 Charlotte Hall Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent 2. Armed Forces?

1 A Yes 2 No. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Self Employed 17. Father's Name (First, Middle, Last)
William K. Harris, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Juanita Kilgore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1804 Gleneagles Lane, Wilmington, NC 28405 John E. Dunn, III 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Parkwood Cemetery 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkville, Maryland 7/12/2010 21. Signature of Funera ²² Burgee Henss Seitz Funeral Home, Inc. Falls Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one caus, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to for as a consequence of Due to (or as a consequence of): yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery Ectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician Medical Examiner

Physician/Medical

þ

Completed

Certificate: To Be

Medical

29a Certifier (Check

30. Name and addres

Physician/

Medical

Director

Funeral

Completed by

Be

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

al Hygiene.

permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Unknown

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a Wasan 24b. Were autopsy findings available

autopsy	prior to completion of ca
performed?	death?
1 ☐ Yes 2 ☐ No	1 🗌 Yes 2 🔲 No
ly one)	

1 Tes 27. Manner of Death 1 Natural 2 Accident 5 Pending Investigation
Could not be Suicide 4 Homicide

25. Was case referred to medical

28a. Date of injury (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28h Time of 28c. injury at 1 Tes

28d. Describe how injury occurred 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death of	occurred at the time, date and place, and due to	the cause(s) and manner as stated
Bb. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day,
	11 / 1(a/)/	7 / 1/ 1/

26. Place of Death (Check on

State Registrar completed cause of death (Item 23a) (Type, Print)

		For State Registrar	State	of Marylar		irtment of H tificate of I		Mental H	ygien Reg. N		21/58		
Physici	an	1. Decedent's Name (First, Middle						2. Date of E Month		ay Yea	3. Time of Death		
/Media	al	Clemen				4b. City, Town, or	Location of Do			2010 Yea	5:30 a M		
Examir	er	4a. Facility Name (If not institution, Frankford Nu.	-	ome		Balt	imore				94.01		
Funeral Director		5. Social Security Number 214 64 4429	6. Sex 1 → M 2 □ F	7. Age (In yrs. 54	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min		$1^{\frac{1}{2}}$	56 9.8	irthplace (State or Foreign Country) MD		
and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits		
Maryl -f sho	tor	MD n/	a			imore					1 XYes 2 No		
ith with the Marylar 23a or 28a-f show	Il Director	10e. Street and Number 1305 E. Laf	ayette	Ave.		10f. Zip Code 212	213		-	Citizen of What O	Country?		
or Items	by Funeral	11. Marital Status 1☆ Never Married 2 Marri 3 Widowed 4 Divorced	Armed F	2 No	1	Vas Decedent of H i Yes, specify Cuba	ispanic Origin? in, Mexican, Pue Specify:	(Specify Yes or Nerto Rican, etc.)	No-	14. Race - American Indian, Black, White, etc. Specify: Black			
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: if flem 27 is marked other than "natural" eny injury or other traumatic event, tra Medical Expanse.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed		(Give life. L	lent's Usual Occupi kind of work done of DO NOT use retired	during most of w	vorking	16b.	6b. Kind of Business/Industry			
Hygier har th		17. Father's Name (First, Middle, I		yrs.	Disa	bled	19 Mothode N	ame (First, Midd		one			
d be fi	o Be	Eulie Hartwe	•					ame (First, Midd Hallb		,			
should nd Me mark imatle	2	19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street a					, Zip Code)		
and 2 alth a 127 is ar trau		Darnell Hart	well (s	ister)	1305	E. Laf	ayette	st. B	alt	o,Md.	21213		
of Her		20a. Method of Disposition 1 □ Burial 2 □ Cremation	2 Domoval from		Place of Dispo	sition (Name of natory or other place		Date	-	Location - City			
Pag ment ant: I		4 Donation 5 Other (Sp		A:	rbutus	Mem.Pk	. July	16,20	10	Balto,	Md.		
permit Depart Import eny in		21 Signature of Funeral Service L	icensee	/ 	C ²	Name and Address	ss Scruc	gs Fun	era	1 Home	7777		
E80	1	23a. Part1. Enter the disease, or	complications that	caus the deat		12 E. F or the mode of dyin				o,Ma.	Approximate		
Physician		Immediate Cause (Final disease or condition	only one cause on			ATIC				ER	Interval Between Onset and Death		
/Medical Examiner		resulting in death)	Due to	o (or as a consec		WD							
*	er	Sequentially list conditions, if any, leading to immediate	b	o (or as a conseq		WD							
uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1										
e exectan an	Exa	resulting in death) Last	Due to	o (or as a conseq	quence of):								
rcate be executed physician and the burial-transit	dicai		d										
n certifi inding use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 Live	utcome of pregna birth 2 ☐ Feta gnant at time of co	al death 3	Ectopic pregnancy Other (specify)				23d. Date of o	delivery Day Year		
that the ed by detacl		Part II. Other significant conditio	ns contributing to	death but not res	sulting in the ur	ideriving cause give	en in Part I.	23e. Dio	d tobacco	o use contribute	to the cause of death?		
w requires that the death been signed by the atte should be detached for	ted by								Yes		Probably Unknown		
	Completed							24a. We aut per 1 🗆 Yes	opsy formed?	death			
sici an : Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			off post Other	00	eath (Check only					
Attending Physician: r death. ector: After this certifica by the funeral director,	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date (Mo		28b. Time of Injury	28c. Injun	4 Winursing	Home 5 Re		6 □Other (S)	oecify)		
i Dift e	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Plac	e of Injury - At h	ome, farm, stro	eet, factory, office			(Street own, Sta		Rural Route Number,		
To the Hospital within 24 hours a To the Funeral completely filled	edicai (29a. Certifier (Check only one) Certifying	xaminer: On the	ne best of my kno basis of examina nner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my of	ne, date and pla pinion, death oc	ce, and due to th curred at the time	e cause e, date a	(s) and manner and place, and d	as stated. lue to the cause(s)		
To the within To the comp	Me	29b. Signature and title of certifier	(1)			29c. License	number		29d. D	Pate signed (Mo	onth, Day, Year)		
61		30. Name and address of person v	who completed cau	use of death (Iter	n 23a) (Type,	Print) Wo	Ma	m W	000	b b	nd. MD212		
Sta Registr		31. Date filed (Month, Day, Year)	2010	Pogistrar's Signa	ature	ake		, , , , ,					
HMH 17 Boy 1/2	201	JUL 13	ZUIU	eren	12. 17								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 14 per fh 9905 7-15-10 yr.
State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Leroy Douglas JMT 8. 2010 Hawthorne 12:18а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 400 Symphony Circle #204 Hunt Valley Baltimore 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, pril 23 1 🛣 M 2 🗆 F Days Hours **Director** 213-36-4753 r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Hunt Valley 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 400 Symphony Circle #204 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. þ 1 Yes 2 No Baltimore, Maryland 21215-0036 Black White 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates. Peacetime Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Music 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Douglas Hawthorne Henrietta Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes M. Hawthorne (Wife) 400 Symphony Circle #204, Hunt Valley, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place)
Loudon Park Cemetery 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 7/12/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death DANKINSON Physician/ disease or condition resulting in death) MNS Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the attending physician and shed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 Live Birth 2 Fetal death If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the aid be detached for 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deat completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles ST touson my State Registrar

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 201^{Year} **Physician** July 111:05 A.M Hock, Sr. John Gerard /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk GenesisElderCare- Heritage | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 13, 1923 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 216-16-9892 7. Age (In yrs. last birthday) 6. Sex Funeral 1⊠M 2□ F 87 **Director** Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modisal Event in that he notified at 1 ☐ Yes 2 ☐ No Director Baltimore City Md. 10g. Citizen of What Country? 10e Street and Number 21224-4502 U.S.A. 4903 Fait Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after MXYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify. δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Body and Fender 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helena Klinehenn Germanus Hock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 4903 Fait Avenue Baltimore, Maryland 21224 wife Philomena A. Hock permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Date 2010 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Sacred Heart of Jesus July 14, 22. Name and Address of Facility Raczorowski Funeral Home, P. A 21. Signature of Funeral Service Licenses 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RIOSCL Immediate Cause (Final KO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and s the burial-tran-Due to (or as a consequence of) Box 68760, Physician/Medical use as the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 \ Unknown 9 🔲 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, p. 25. Was case referred t edical examiner? 26. Place eath (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Regist DHMH 17 Rev 1/20

	Chats of Manual of Dan		•	•
	1 - For State of Maryland / Dep Registrar Ce	rtificate of Death	, ,	N2010 21761
an	1. Decedent's Name (First, Middle, Last)	Tahnaaki	2. Date of Death Month	Day Year 3. Time of Death
cal	Melvin Joseph	Ichnoski	Sr. July 10,	
ner	4a. Facility Name (If not institution, give street and number) 1206 Keywood. Court	4b. City, Town, or Location of Dundalk	of Death	4c. County of Death Baltimore
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under		
	213–26–7522	Months Days Hours	Min. (Month, Day, Young) December 22	,1930 Maryland
	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
ctor	Maryland Baltimore Dund	alk		1 □Yes 2 □ No
Completed by Funeral Director	10e. Street and Number	10f. Zip Code 21222	10g	. Citizen of What Country? USA
eral	1216 Delbert Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13.		inin? (Specify Yes or No-	14. Race - American Indian,
F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican		Black, White, etc.
d b	3√2 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify: White
olete	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)	t of working	b. Kind of Business/Industry
mo	Elementary/Secondary (0-12) College (1-4or 5+)	les		Clothing
Be	17. Father's Name (First, Middle, Last)	1	er's Name (First, Middle, Mai	
ပ္	John Ichnoski		e Mazurkiewio	
	19a. Informant's Name/Relationship (Type. Print) Melvin J. Ichnoski Jr. son 19b. Maili 1206	ng Address (Street and Number Keywood Court	e, Dundalk, Mai	ryland 21222
	20a. Method of Disposition 20b. Place of Disposementery, cree 20b. Place of Disposementery, cree 20cemetery, cree	osition (Name of matory or other place)	July 13.	c. Location - City or Town, State
	4 Donation 5 Other (Specify) Sacred Hear	t of Jesus Cen.	2010 Di	undalk,Maryland
	21. Signature of Funeral Service Licensee 7	onnelly Funera 1110 Sollers Po	il Home Of Dur Sint Road, Dur	ndalk,P.A. ndalk,Md. 21222
	23a. Part 1. Enter the dise so, or complications that caused the death. Do not en shock, or heart failur. List only one cause on each line.	ter the mode of dying, such as	cardiac or respiratory arrest	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	larcin,	oma	
	Due to (or as a consequence of):	S		
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C			
calE	d d			
Medi	IF FEMALE.			
ian/N		☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
Completed by Physician/Medi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		,
by Pt	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	. 23e. Did tobac	cco use contribute to the cause of death?
ted	Platter Mari	172	1 ☐ Yes	2 No 3 Probably 4 Unknown
mple	Hy prelension		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
	25. Was case referred to medical	00 Blass	1 ☐ Yes 2	No 1 ☐ Yes 2 ☐ No
o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othori	of Death (Check only one) ursing Home 5 Residence	on 6 Other (Carallel)
T:U	27. Magner of leath 28a. Date of Injury (Month, Day, Year) Injury		28d. Describe how	
catic	2 Accident investigation	M 1 ☐ Yes 2 ☐		
ertifi	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Medical Certification: To	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or in and money of the control of the contr	th occurred at the time, date ar evestigation, in my opinion, dea	nd place, and due to the cau ath occurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
Mec	29h. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, MOHA MAAD 31. Data filed (Montana Pari) 32. Registar's Signature	D00211	559 -	7/10/10
	30. Name and address of person who completed cause of death (Item 23a) (Type,	23 SHi Plin	a lac B.	et mp 2/222
te	31. Date filed (Month State) 32. Registrar's Signature	X		
ar				

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Pikesville Envoy of Pikesville Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Min. Months Days Hours 1XM 2□F 438-26-3819 1-1-1921 TΑ Director 89 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Owings Mills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21117 120 Embleton Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or iter 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: African-American Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur and Injury or other traumatic event, the Medical ong. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) B & O Railroad Terminal Superintendent 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rubie Granger Gros Julian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 120 Embleton Road, Owings Mills, MD 21117 Sherry Julian/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Veterans 7-14-2010 Owings Mills, MD Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. ure of Funeral Service Lice 9200 Liberty Road, Randallstown, MD 21133 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 11. Enter the disease, or complications that court ock, or heart failure. List only one cause on each cerebral Immediate Cause (Final disease or condition resulting in death) Atheroschectie part Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ending physician use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ♣ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No his certificate has buildirector, page 2 s 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Other: Hospital: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient this 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: After 5 ☐ Pending investigation 1- Natural 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death

To the Funeral Director: completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 037573 B) 5010 0+1 se of death (Item 23a) (Type, Print) 30. Name and address of person who completed cal 32. Regi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:55 AM Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death pinac **Funeral** Social Security Number 7. Age (In vrs. last birthday) If Unde 1 Year If Urticle 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Months Country) Min (Month, Day, Director -38-099C)hio Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 9100 12: Was Decedent Ever Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ✓ Yes 2 ☐ No o. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No "natural". 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked ပ and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11) 21009 spouse KU or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date UNK Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) le:tro I nen I Service Licenses 21. Signatur 22. Name and Address of 1935 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician: disease or condition METASTATIC ISOPHAGEA TEM Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate Examine Dire to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or linjury the attending physician and hed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the hi date and place, and due to the caucate) and mainter ac stated 29b. Signature and title 29c. License number PHYSE CE AL D005847 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IP NJLA 602 32. Registra filed (Month, State 's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O7 10 2010 Racheal Louise Jones 3:46a.™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6201 Loch Raven Blvd Unit 608 Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth **Funeral** 1 M 2 Days O1 O5 Year) Hours Min. 68 **Director** 247-70-9335 SC show 10a. State 10b. County . Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f MD NA Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6201 Loch Raven Blvd Unit 608 21239 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 9 δ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced Black permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+yr Administrator VA Hospital 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fannie Naomi Turner Thomas Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianna Road, Richmond, VA 23231 Jamison E. Brown-Nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ki Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sandsbury 7/17/10 Timmonsville, SC 21. Signature d **#**uneral Service Licensee Marchand Adors of Seilyt Baltimore, Md 4300 Wabash Ave, 21215 23a. Part 1 Enter the disease, or complications that course shock, or heart failure. List only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death MASMAL UNKnown Physician/ cancel disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): nding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Aftert 28c. Injury at 28d. Describe how injury occurred 1 💹 Natural 5 Pending ours after death.

neral Director: Aft
filled in by the fur 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

32. Registrar's Signature

10-05139 Theus Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 21765 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 9, 2010 **Medical Examiner** 0837 hrs F. Johnson Theus 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 509 E. 38th Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign 212 58 7738 Hours Director Aug. 27, 1950 1 M 2 X F 59 Country) Usual Residence of Decedent ıny 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ust be notified at once. 1 Yes 2 No MD n/a Baltimore hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 509 E. 38th St. 21218 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 Never Married 2 Married 2 × No Yes Specify: Black 4 Divorced If Yes, Give Year Yes 2 No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry Completed Department of Health and 2 should be filed within 72 hou Department of Health and Mental Hygiene. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Nursing Home Nurses Aide semester 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) t: If item 27 is marked other traumatic event, f Horace Johnson Dorothy Wilson Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia O'Neal (sister) 509 E. 38th St. Baltimore, Md. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place)
Green Mount Crematory 10 Baltimore,Md. 1 Burial 2 X Cremation 3 Removal from State 13,20 Donation 5 Other Specify. gnature of Funeral Service Licenses Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto Md Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Complicated by Hyperthermia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property or After this certificate has been signed by the attending physician and attending physician and or use as the burial - trans Physician/Medical UNPENDED AMENDED 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Box 1 Yes 2 No 9 ✓ Unknown a signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? P.O. þ 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed Records, has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA 1 Yes No 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification Subject exposed to high environmental Natural **FOUND** Division Pending 1 Yes 2 ✔ No Director: d in by the f temperatures 0800 hrs 2 🗸 Accident Jul 9, 2010 Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) 509 E. 38th Street, Baltimore, MD determined (Specify) Single Family Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca To the I within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. July 9, 2010 MUS 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD **Assistant Medical Examiner** 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Charles Z.528M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Social Security Number 7. Age **Funeral** Months Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination and once. 0d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No Funeral Director MAKYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED 12. Was Decedent Ever in U.S. Armed Forces?

1 MYes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ð 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENGINECK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NOTTINGHAM, MARYLAND 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State JULY 16 2010 TIMONIUM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility 8870

EVANS FUNERAL CHAPL

23a. Part 1. Enter he dise te, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or liberat failure. List only one cause on each line. 22. Name and Address of Facility 8800 HARFORD ROAD PARK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 □ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 9,2010 **Physician** John Patrick Kirby Sr 9:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7905 34th Street Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/27/1950 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F Months 220 54 7642 60 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be reserved. 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Rosedale Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34th Street 7905 21237 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Mechanic Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Hudson Mary Eleanor Cypher Kirby 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34th Street Rosedale Maryland 21237 7905 Charlene Geary (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/12/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory 22. Name and Address of FacilityBruzdzinski Funeral Home PA of Funeral Same License 1407 Old Eastern Avenue Essex Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition esulting in death) **Physician** ardiony o path years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babo, MP. 2 R21 1124 U 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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2			-	State Registrar					Cer	tificate	of E	Death			Reg. N	201	U	21	768
0933		Physicia Medic		1. Decedent's Name Richa	•	, _{Last)} ich Krebs	3			2. Date of Death Month July 10, 2							Year	3. Time o	of Death 3 A M
4		Examin		4a. Facility Name (if not institution, give street and number) 4b. (Shady Grove Adventist Hospital.								Location	of Death			c. County			
2010	and d			Shady (5. Social Security No	birthday)	Ro If Under	ckvi.	Lle If Under	24 Hrs.	8. Date of B		Montgo		nlace (State	or Foreign				
		Funeral Director		579 56 Susual Residence of	3096	6. Sex 1	c .	56	Yrs.	Months	Days	Hours	Min.	Jan 2,	1944	9. Birthplace (State or Foreign Country) Washington DC			C
2		and show	ō											10d. Inside (
14		Maryl 28a-f otifiec	rect	Maryland Montgomery Upper Maroboro Montgomery Village											es 2 XXNo				
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	920	s after death ral", or items Examiner m	Completed by Funeral Director	11. Marital Status 1 😿 Never Marr 3 🗆 Widowed		ried Armed	ecedent Ev Forces? es 2 X Give r Dates.			Vas Deced Yes, spec				cify Yes or No Rican, etc.))-		k, White,	etc.	
5	2-0	hour matur dical	olete	(Spe	15. Deceder	nt's Education est grade complet	ted)		16a. Deced	ent's Usua	al Occup	ation during mos	st of worki	na	16b	Kind of Bu	siness Ir	dustry	
KREBS	21215-0036	vithin 72 jiene. er than " the Med	Comp	Elementary/Sec			e (1-4 or 5-	+)	life. Do	D NOT use	e retired)	T Prog				echhec			
<u>Z</u>	land ?	17. Father's Name (First, Middle, Last) Hilmer H. Krebs 18. Mother's Name (First, Middle, Maiden Surna Alice Robinson									n Surname,)							
PD	Maryland																		
RICHARD	ore,	of Her		20a. Method of Dis	position	3 Removal f	rom State	20b. Plac	ce of Dispo	sition (Nar	ne of other plac	ce)		Date			-	own, State	
5	im	201 1 2 Cremation 3 Removal from State Cedar Hill Cemetery, crematory or other place) Cedar Hill Cemetery July 16, 2010 Suitland, Me										_							
3	20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 Donymon 5 Other (Specify) 21. Signature of Funeral Service Life (See 2) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Of Control of											Old Ale	xandria						
		HD = 60		Part Enter	the disease of	complications th	nat caused	the death.	I Fe	er the mod	Road. de of dvir	Clint ng. such as	on. M	D 20735 or respiratory	arrest,			Approxim	nate
		Dhusisian/		shock, or hea Immediate Cause	art failure. List o	only one cause or	n each line.											Interval B Onset an	etween d Death
		Physician/ Medical		disease or condition resulting in death)		a. Due	to (or as a	iac onsequer rater	nce of):	1717							_		
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\	D.	executed an and ial-transi	xan	Cause (Disease or that initiated event resulting in death)	TS	c. Due	4501 to (or as a	ra-110 a consequer	nce of):	neu	mor	1700					-		
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	. Box 68760	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?	1 0 1	_ive Birth	of pregnance 2 Fetal of t time of dea	death 3 L	Ectopic Other (s		су					te of deli	very Day	Year
	P.O.	sician: The law requires that the de- certificate has been signed by the i rector, page 2 should be detached		Part II. Other signi	1 1 1				ting in the u	underlying	cause g	iven in Par	rt 1.					the cause o	
	ds,	quires en sign	ted t	alcoho	ILIVE	r cirr	19917				-			1 [Yes				Unknown
	cor	aw rec as be	Completed by											24a. W	topsv	24b.	Were aut prior to d death?	opsy finding ompletion o	gs available of cause of
	Re	The la	Con											1 🗆 Ye	erformed s 2	No		2 🗆 No	
	tal	ician: sertific ector,	Be	25. Was case refer examiner?		Hospital:					Ott			k only one)					
	Į V	Phys r this ral dir	으	1 Yes 2 27. Manner of Dea	∯No th		1 De Inpatie Date of injui Month, Day	ent 2 E	8b. Time o		28c. Inju	ryat	Nursing H	ome 5 Re 28d. Describ				<i>ty)</i>	
	o u	nding ath. : After e fune	icate	1 Natural 2 Accident	5 Pendi	ng (igation	Month, Day	y, Year)	injury	М	wor 1 E	k? Yes 2	□No						
	Division of Vital Records,	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director. After this completed filled in by the funeral director.	Certificate:	3 Suicide 4 Homicide	6 Could	not be 28e. F	lace of Inju	ury - At hom	ne, farm, sti	eet, facto	ry, office			28f. Locatio City or	n (Street : Town, Sta	and Numb	er or Rui	al Route Nu	mber,
	ם	e Hospita 124 hour Funera leted fille	Medical	(Chook	2 Medical	g Physician: To the Examiner: On the g Nurse Practio	hasis of e	vamination a	and/or inves	stigation, in	n my opin	ion, death	occurred a	at the time, da	te and pla	ice, and du	ie to the o	cause(s) and	manner stated
		To the To the Comp	2	29b. Signature and	d title of certifie	er				29	c. Licen	se number						, Day, Year)	
				•	Meh							064				-19			
		12		30. Name and add			cause of d	leath (Item 2	23a) (Type,	Print) Mecli	cal	centr	er D	r. Roc	Kvill	e, N	ary	land	2085
		Sta		31. Dilled M	1201 (Jear)	Deneva	2. Reostra	ar's	A. C.										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JuMenth 7, 2010 Τ. LaVardera 4:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium 5. Social Security Numbe Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🌡 F June 5, Months Davs Hours Year 925 85Yrs MaryTand Director 219-16-2673 Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Mediral Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Timonium MD Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Completed by Funeral 21093 IISA 2300 Dulaney Valley Road within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?
1 ☐ Yes 2 💆 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 Married 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Rowley Genevieve Trageser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Panella/Daughter 511 Whithorn Ct. Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of July 12, 2010 20c. Location - City or Town, State cemetery crematory or other place)
Dulaney Valley
Memorial Gardens 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Signature of Funeral Se Inc. Hichael J. Flasle 23a. Part :- Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on e. ch line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ CU CONIC Medical resulting in death) Due to (or as a consequence of Examiner Pars 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician; The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): Box 68760 f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death signed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed. Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 2. No 1 🗌 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) B B Other: 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 1 Natural (Month, Day, Year) 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital Medical 29a. Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the F 3 Certifying Nurse Practioner: To the best of my knowle pe, death occurred at the time, data and place, and due to the cause(a) and majors as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD MD21093 ERNESTINE WRIGHT, M.D. TIMONIUM

Registrar

MARY JANE

LAVARDERA.

		For State Registrar	S	tate o	f Maryla		epartr Certifi				nd Me	ental Hy	giene Reg. No	7 B C D	2	17	70
		Decedent's Name (First, Middle	, Last)					-			2	2. Date of De				ne of D	Death
Physicia Media		Mary Dorothy L	ovele	SS								Month July	Day	2010	1	28	Ма
Examir		4a. Facility Name (if not institution	give stree	t and numi	ber)		4b.	City, Tow	vn, or Lo	cation of D	Death			County of Deat			
		7901 Laurel La	kes C	ourt,	Apt.	230		Laure	e 1				Prince George's				
Funeral		5. Social Security Number	6. Sex 1		7. Age (In yrs		Mo	Under 1 Y		Under 24	Hrs. 8	B. Date of Bir	rth		hplace (St	ate or i	Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	힏		Peter	Hab	nen				1 18		_ `	First, Middle,		urname)			
nould nd Mi mar mati		19a. Informant's Name/Relationsh			7011	19h	Mailing Ad	drace (Str	reet and		ela r Bumi B	Wagn		оwп, State, Zip	Codal		
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o iii iii		J. Ken Stil	٤		M0105	53	313	3 Tal	bot	t Ave	nue,	Lau	rel,	MD 20		• A •	
		23a. 1-11 1. Enter the disease, or shock, or heart failure. List o	complication	ons that ca	used the dea	ath. Do no									Approx		
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Medical		resulting in death)	₽ a. −		r as a conse			ıa							4 ye	ars	
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or At after of Direct in by	ਲੂ ਜੁ	4 Homicide determi		le. Place o building	f Injury - At h j, etc. <i>(Speci</i> i	ome, farm fy)	ı, street, fa	ctory, offic	ce		28f.	Location (S City or Tow		Number or Run	al Route N	umber,	;
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

10-05028
Kasev Lambert

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Physici	an/	Registrar 1. Decedent's Name (First, Midd)	le,Last)						12	2. Date of D	Reg. No	10.		3. Time of D	• • •	i
ledical Exam		Kasey	Lambert							Month July 5, 2	Da 2010	y Yea	r	0608 h	rs	
		4a. Facility Name (if not institution		umber)	4	b. City, Town	, or Lo	cation of	Death	,		4c. County o	f Death			1
		2012 Deering Avenue				Baltimore	е									
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under	24Hrs.	8. Date of	Birth (M	IM/DD/YYYY)			e or	1
Director		214-17-6515	1 M 2 X F	28	Yrs.	Months	Days	Hours	Min.	Apr.	26.	1982	Foreigi Cou	n untry) Mar	vland	
		Usual Residence of Decedent							L	F	,				J	┨
any		10a. State 10b. County		10c. City	, Town or Location	on								10d. Inside	City Limits	1
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with t		11. Marital Status		cedent Ever in U	.S. 13. Was	Decedent of		nic Origin	? (Spe	cifv Yes or	No-	USA 14. Race	- Americ	an Indian, B	llack.	┨
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her do		3 Widowed 4 X Div	orced If Yes, Give Ye	2 X No	1 🗆	Yes 21	No s	specify:				Specify:	whi	to		ı
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5-0036 iled within 7' Hygiene. I other than	Cor	17. Father's Name (First, Middle,										en Surname)				ĺ
215 be fill ntal H rked	Be	Michael D. Lam	bert				D	ebra	A R	ankir	n					
21 ould I Mer s mar	To	19a. Informant's Name/Relations			19b. Mailing	Address (S	treet ar	nd Numbe	er or Ru	ral Route N	Number,	City or Town	, State,	Zip Code)		
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e, land Heal		20a. Method of Disposition			Place of Disposit		cemet	tery,		Date	20	c. Location -	City or 1	Γown, State		
nor ages ant of att. If		1 X Burial 2 Cremation		OIN State	1		TO .	ark	T., 1 .,	0.20	11	Ellerid	go l	MTD		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient April and Innoversative if tiem 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	1	4 Donation 5 Other St. 21. Signature Funeral Service		IME	ad owrid g 22. Na	me and Add	ress of					eral H			nedow	10
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Division Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		4 Homicide	(opening)	been						Balto	, M	d. 212	30_	-		
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 8-24PM **Physician** GREGORY JULY MORRISON 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NA Baltimore Hospital BonSecours . Age (In yrs. last birthday) 54 Yrs. Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs Sex M☐ M 2☐ F **Funeral** Months Days Hours MD 214-68-3648 Director Usual Residence of Decedent 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Martical Event in a full find a once. or 28a-f show X MYes 2 □ No Baltimore NA MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21217 1819 Arunah Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. African XXNever Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: American ģ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Downtown Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Partnership Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Morrison Francis Jackson Clarence ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1819 Arunah Avenue Baltimore, MD 21217 Gloria Drummond-Sister 20b. Place of Disposition (Name of Cemetery crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 07-14-10 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Ser 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL ACUTE Physician disease or condition resulting in death) /Medical Examiner IMMUNODEFILIENCY LAUIRED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ARTERIOSCLEROTIC Hospital or Attending Physiclan; The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No this certificate has been signed by the an director, page 2 should be detached it 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🕱 No 1 ☐Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Plnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 1 🗷 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D 23360 JULY 08 2010 MD. SECOURS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA250: 54. BALTO MD. 21223 PAIZE2 SUDICIR. 2000 W1 32. Registra s Signa ore 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#5 per FH, G905, 7/14/2010, WS
State of Maryland / Department of Heatin and Mental Hygiene
amend 1tem 18 per fn g905 /-16-10 vt

Certificate of Death

Reg. No. 2010 1. Decedent's Name (First, Middle, Last) 2. Date of Death ARGARET R. MILBURN Physician/ Month 1:37 2010 Medical 4a. Facility Name (if not institution, give street and number **Examiner** Location of Death 4c. County of Death nan If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Days Min. Hours 60 Country) Director 10-19-1949 Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location
Baltimore notified at with the Maryland 10d. Inside City Limits Director MD n/a 1 X Yes 2 □ No 10e. Street and Number ò 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 10g. Citizen of What Country? Funeral 21201 708 Martin Luther King Blvd USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 No
If Yes, Give
Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Completed 3 X Widowed 4 □ Divorced Specify: African-American 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ARC of Baltimore Counselor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Randolph Phillips Goldie Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Phillips/ Daughter 7201 rutherford Green Circle, Windsor Mill, MD 21244 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ₩ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-17-2010 Cedar Hill Cemetery Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Immediate Cause (Final Interval Between Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day 🛮 No 1 Yes : Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an neral Director: After this certificate has I filled in by the funeral director, page 2 s autopsy perform Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defining in figure 1. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) nd title of certifie 29b. Signature 056399 30 Name on who completed cause of death (Item 23a) (Type, Print) Baltimore N Paul led (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death (a: 20 M Physician/ Year 40 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** mD west Nursing + Rehab 13 timo a 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 5 21 __26 1 ☐ M 2**X** F Months Hours Country) 218-22-3424 Director 84 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits Director 1 X Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3202 Auchentoroly Terrace 21217 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3X☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private 6th grade Domestic Worker na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Andrew Mason</u> Anna Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Alice Tucker-Niece</u> 3202 Auchentoroly Terrace, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 7/13/2010 Baltimore, Md Zion Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Av Ave, <u>Baltimore.</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Donknown after death.

Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 DHO 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a **To the Funeral C** Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State 1 3 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:52am hard Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death tan If Under 1 Year 9. Birthplace (State or Foreign Country) If Under 24 Hrs Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1 M 2 D F Months (Month, Day, Yrs. Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No timure 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21206 Venue 12. Was Decedent Ever in U.S. Armed Forces? 1 → Yes 2 → No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Blac Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. anner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle_Maiden Surname) ည hmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or other men ora 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State Date pemetery, crematory 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Kan au 23a. Part 1. Ent rithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the int failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ emia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: I within 24 hours after death.
To the Funeral Director: After this certifics **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tyes ဂ္ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury work? 5 Pending 2 🗌 No Director: / Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Funeral Direct completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title July 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch

Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

MANG

9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237

30. Name and address of Ars in who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 9, 2010 PATRICIA ELLEN MOORE 7:18 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford 1513 Cedarwood Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 6, 1953 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Texas Director 56 461-06-2855 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No <u>Maryland</u> Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 21014 USA 1513 Cedarwood Drive filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 🙀 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. other than " vent, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) Contracting Officer U.S. Government 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even ပ္ Cecil (unk) Moore Dorothy (unk) Wendt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1513 Cedarwood Drive, Bel Air, MD 21014 Charles A. Comaty / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-16-10 Darlington, Maryland Darlington Cemetery 22. Name and Address of Facility
McComas Funeral Home, Signature of Funeral Service License athleen Santwas cu Maryland 21009 1317 Cokesbury Road Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Parkinson's Disease Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate couse. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death ed by the a 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? certificate 1 Yes 2 X No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Kesidence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending work? To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Afi completed filled in by the fur 1 🗌 Yes 2 🗌 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) marra W Kes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DV

DHMH 17 Rev 7/2009

Registrar's Signat

Liana Rosenthal The Johns Hopkins Hospital, 600 N. Wolfe St., Balto., MD 21287

10-04843 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kerede Odusote State of Maryland / Department of Health and Mental Hygiene 2010 21778 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner June 28, 2010 0428 hrs ODUSOTE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Doctors Community Hospital** Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign NIGERIA **Funeral** Min Months Days Director MAY 7 1977 33 215-73-4898 1X M Country) Usual Residence of Decedent iny 10a, State 10d. Inside City Limits 10c. City, Town or Location s 23a or 28a-f show e notified at once, GREENBELT 1 X Yes 2 No PRINCE GEORGE'S death with the Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20770 USA 6015 SPRINGHILL DRIVE ۵ Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married 2 X No "natural", or Yes Desirmore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after c.
Department of Health and Mental Hygiene.
Important: If item 27 is month. 3 Widowed Divorced If Yes, Give Year Yes 2 X No specify: Specify: BLACK \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ narked other than ' GOVERNMENT CORRECTIONAL OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be T. ODUSOTE FUNMILAYO OLA J. ODUSOTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) litem 27 is martic e 5622 WHITFIELD ROAD # 103 LANHAM, MARYLAND 20706 BANKOLE F. ADOJU/BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date t: If it crematory or other place) 1 Buriai 2 Cremation 3 Removal from State WASHINGTON NATIONAL CAME 7/10/10 SUITLAND, MARYLAND 4 Donation 5 Other Specify 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Multisystem organ failure Examiner or condition resulting in death) Due to (or as a consequence of): Invasive group A Beta-hemolytic streptococcal infectio Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated MI Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical ttending physician a UNPENDED AMENDEPine a-b, PII, 27, per ME g905 7/22/10 TT Division of Vital Records, P.O. Box 68760, 23c. If ves. outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the 2 Fetal death signed by the attending be detached for me Live birth Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 V Unknown Colorectal polyps Completed has been si 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of perform<u>ed</u> death? this certificate ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one Be examiner? Other₄ Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes No 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural death. Director: Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 } Medica To the one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 29, 2010 O.C.M.E. Wa

State Registrar

DHMH 17 Rev 1/2001

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111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

31. Date filed (Month, Day, Year) JUL 13 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Dale of Death 3. Time of Death Physician/ 3350 Medical 4a. Facility Name (if not institution, give street and nu Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 502 Oakland Avenye n/a Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 XM 2 - F Director 215-40-8058 66 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The Mental Hygiene mant if flem 27 is marked other than "hatural", or items 23a or 28a-f show and it flem 27 is marked other than "hatural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Baltimore MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 502 Oakland Avenue 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African-American 3 Widowed 4 Tip Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Assembler General Motors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Pringle Sr. Annie Mae Flemming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Moore/Sister 3715 Oak Avenue, Gwynn Oak, Md 21207 Department of Health Important: If Item 27 any injury or other trong once, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 7-15-2010 Woodlawn Maryland 21. Signat re of Funeral Service Licensee 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Fart 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lim the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) . Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🔲 No Be (within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Karen G. Pullara . Medical July 2010 2:30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Stella Maris Hospice Timonium 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min 1 🗆 M 2 😾 F october 13 56 Director 219-58-1190 Baltimore, Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director PA York Hanover 1 🗌 Yes 2 😾 No 10f. Zip Code 17331 10e. Street and Number 10g Citizen of What Country?
United States Funeral 70 Blue Heron Drive America 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Importantt If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin one. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2XXNo Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick W. Tolson Mary Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
70 Blue Heron Drive Hanover, Pennsylvania 17331 Mr. Harry C. Pullara/ husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State $\operatorname{Julv}^{\scriptscriptstyle{\mathrm{Dat}}}$ 4.cemetery, crematory or other place) Evans Funeral 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Forest Hill, Maryland <u>- Bel Air</u> hape. Signature of Funeral Service censes 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ a. LUNG CANCER Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the huneral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 2 🗶 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

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12:30 а.ш.

2010

KAREN PULLARA

Registrar

JACKIE JONES,

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

son who completed cause of death (Item 23a) (Type, Print)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DY ON 2070 Medical Facility Name (if not institution, give street and number) **Examiner** Gity, Town, or Location of Death Hospital (andalls Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth
(Month, Day, Year) **Funeral** 1 M 2 D F Months Days Hours Min. Director 84 165-12-2588 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland n and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore Randallstown 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 9011 Hamor Road 21133 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black 3 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than ementary/Seconday (0-12) College (1-4 or 5+) 12th grade Postal Truck Driver Post Office na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ if. Page 1 and 2 shours of Health and Mr or 27 is mr <u>Nelson Durious Pryor</u> ucy Pratt Bumbry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Wilhelmenia Pryor-Wife</u> Hamor Road,, Randallstown, Md 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 🚻 Burial 2 🗌 Cremation 3 🔲 Removal from State Garrison Forest Vet 7/15/2010 Owings Mills, Md 4 Donation 5 Other (Specify) ure o Funeral Service License 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Sign 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediat Cause (Fine) Onset and Death Physician/ Therosc 0 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 **X**No Other: ည 1 🗌 Yes 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No neral Director: A I filled in by the fi 2 Accident
3 Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of cert

State

Registrar

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proppleted cause of death (Item 23a) (Type, Print)

and address of person who

VILLU

Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Harry Cody Press, Jr. July_ 4 2010 6:08 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 6745 New Bold Drive Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Y 1 🛛 M 2 □ F Months Days Hours Min. 224-38-0746 **Director** 78 931 Chesapeake Va Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6745 New Bold Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 Specify: African American If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) R<u>adiologist</u> Medical 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Cody Press, Sr. Vianna Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Francella Teele Press/wife</u> 6745 New Bold Drive, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Burial 2 X Cremation 3 - Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory:07/09/2010 Beltsville Maryland ture of Funeral Service Lic 21. Si 22. Name and Address of Facility McGuire Funeral Service, Inc. <u>7400 Georgia Avenue.N.W. Washington,D.C.</u> 23a. Part 1. Enter the disease, ou complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Metastatic Prostate Cancer Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Rectal Cancer 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy performed? 1 Yes 2 No Yes 2 X No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending injury Accident 1 Yes 2 No s after death Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifier Cerunying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
In edical examiner: On the basis of examination and/or inversign, in my opinion, death occurred at the time, date and place, and due to the caus (Check yon, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

OXI

To the I within 2

State

Registrar DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

only one

29b. Signature and titl

ertifying Nurse Practioner:

30. Name and address of rson who completed cause of death (Item 2, a) (Type, Print)

of ce

Wayne Frederick, M.D.

the best of my knowled

29c. License number

MD30905

death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

July 8, 2010

ames W. Poe, .		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Reg. No.
Physicia Medical Examin		1. Decedent's Name (First, Middle, Last) James W. Poe, Jr. 2. Date of Death Month Day July 3, 2010 3 Time of Death 2115 hrs
		4a. Facility Name (if not institution, give street and number) 3690 Ash Street 4b. City, Town, or Location of Death Baltimore 4c. County of Death N/A
Funeral Director		5. Social Security Number 220-78-5997 7. Age (In yrs. last birthday) 51 Yrs. 16. Sex Months Days Hours Min. Aug 11, 1958 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months) Country) MD
nd show any	_	Usual Residence of Decedent 10a. State
with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Number 3690 Ash Street 10f. Zip Code 21211 10g. Citizen of What Country? U.S.A.
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene item 27 is marked other than "matural", or items 23a or 28a-f short reaumatic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1
5-0036 led within 72 hours Hygiene other than "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) James W. Poe, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Ruth elizabeth Parlier
MD 2121 d 2 should be fi lth and Mental nn 27 is marked numatic event,	입	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1740 Gray Hawk Ct. Estes Park, C0 80517
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum:		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory 7/09/10 Glen Burnie, MD
Balti permit. Departn Import		21 Signature of Funeral Service Licensee 22 Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211
Physician /Medical aminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a, Atherosclerotic Cardiovascular Disease
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.
	Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated
60, ate be executed hysician and te burial - transit	al Ex	d.
'60, ate be ex physiciar ne burial	Medic	UNPENDED AMENDED IF FEMALE: 23d. If yes, outcome of pregnancy 23d. Date of delivery
Sox 6876 death certificat e attending ph	Physician/I	23b. Was decedent pregnant in the past 12 months? 1
ords, P.O. E w requires that the d is been signed by the should be detached	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Reco	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
Vital F ysician: 'ysician: his certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1
tending Ph		27. Manner of Death 1 V Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No
Divis pital or At ours after d cral Direc	Certification:	3 Suicide 6 Could not be determined Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hosp within 24 ho To the Fun completely 1	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) July 8, 2010
HV		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature
DHMH 17 Rev 1/20	01	OCME ORIGINAL

		1 - For State of Maryland / Dep Cells Registrar Cells	artment of Health and Mental I	Hygiene 2010 21784				
Physici Med		KILAWID PIONIL II	2. Date of Month フィル	f Death 3. Time of Death Day Year				
Exami			4b. City, Town, or Location of Death Parkville	4c. County of Death Baltimore				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 215-44-2295 1 M 2 \square F 65 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month See	Birth 9. Birthplace (State or Foreign Day, Year) 1944 Maryland				
yland f show ed at	Şç	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits				
the Mar r or 28a- be notifii	Funeral Director	MD Baltimore Parkvi	10f. Zip Code	1 ☐ Yes 2 No				
eath with	unera	8304 Beryl Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Variables of the status of th	21234 Was Decedent of Hispanic Origin? (Specify Yes or I	United States				
Maryland 21215-0036 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Completed by F	1 Never Married 2 Married 1 Never Married 2 Married 1 Ves 2 No 1 Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 MNo Specify:	14. Race - American Indian, Black, White, etc. Specify: White				
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. ZT is marked other than "natural", o traumatic event, the Medical Exam.			dent's Usual Occupation kind of work done during most of working O NOT use retired) tomotive Body & Fender	16b. Kind of Business Industry Automotive				
yland d be filed Mental Hy arked oth	To Be		18. Mother's Name (First, Midd Catherine					
<u>~ ○ ≅ ⊘ ₹</u>			ng Address (Street and Number or Rural Route Num 304 Beryl Rd. Parkville					
Baltimore, bermit. Page 1 and Department of Hea mportant; If item any injury or other			sition (Name of natory or other place) pake Crematory	20c. Location - City or Town, State Beltsville, Maryland				
Baltimo permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee 22	NameremathsonFamind Funeral .	Alternatives ve Towson Maryland 21286				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respiratory	/ arrest, Approximate Interval Between				
Physician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death) End_Stry L Lwd Due to (or as a consequence of):	Tompopainy	Onset and Death				
-5		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
/ 60 cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or iinjury that intitated events resulting in death) Last c. Due to (or as a consequence of):						
/60 cate be e physicial the buri	edical	d						
box 68 be death certification the attending the for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Ves 2 □ No 9 □ Unknown Ves 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □ 9 □ Unknown	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year				
Lires that the signed by lid be detact	þ	Part II. Other significant conditions contributing to death but not resulting in the u		d tobacco use contribute to the cause of death?				
JUNISION OT VITAI RECORDS, all or Attending Physician: The law requires is affer death. In Director: After this certificate has been sig ad in by the funeral director, page 2 should b	Completed		pe	prior to completion of cause of death?				
rtal r sician: T certifica irector, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Insertion 1 To Insertion 2 To	26. Place of Death (Check only one)	es 2 No 1 Yes 2 No				
on or v nding Physath. r: After this e funeral d	icate: To	27. Manner of Death 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Inpatient 2 ER/Outpatien 28a. Date of injury (Month, Day, Year) injury	t 3 DOA 4 Nursing Home 5 Re	esidence 6 Other (Specify) be how injury occurred				
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he Hospit in 24 hour he Funera pleted fillk	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of my knowledge, death of the basis of my knowledge, death of the basis of examination and/or investigation of the basis of my knowledge, death of the basis of my knowledge, death of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination of the basis of the basis of the basis of examination of the basis of	igation, in my opinion, death occurred at the time, dat	te and place, and due to the cause(s) and manner stated				
70 th with com		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr N - S ・ RajapaKH /M・D・ 2535	int) smith Av-s- 235-	- Baltimore, MP. 21209.				
Stat Registra		31. Date filed (Month, Day, Year)						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Kenneth Allen Record July 12:30 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 100 North Potomac Street #309 Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0ct 13, 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 17√2 M 2 □ F New York Director 64 Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at Director MD Washington 1 ☐ Yes 2 ☑ No Hagerstown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ō 100 N. Potomac Street #309 21740 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or Specify: White 1 ☐ Yes 2**X** No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unik (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental Robert Charles Record Lillian Marie Davis ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau Jacqueline Hetterly - sister 5803C Oleander Place; Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State 21. Signature of Service Mensee Nayl ^{22.} State Address (Facility Board; 655 W. Baltimoore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIGIPEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the SS IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an After this certificate has page 2 1 □ Yes 2 🛂 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and man 29b. Signatur and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

Ko,

Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUME 30° 20**°f**ö ALFRED ROGERS 2:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death HARFORD **Examiner** 4b. City, Town, or Location of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Nov 5, 1921 1 🖾 M 2 🗆 Months Days Hours Min. New York Director 073-20-8249 88 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 XNo Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 820 Delray Drive 21050 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

YE Yes 2 No 1944If Yes, Give 1946 Black. White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: 1946 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) engineer Be Page 1 and 2 should be filed ment of Health and Mental Hy ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Patnode Alfred Morehead Rogers Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Rogers - wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 820 Delray Drive; Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☑ Other (Specify) Signature of Funeral Service Licensee Nay1 22. State Admatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year 4 ☐ Pregnant a Pregnant at time of death Month Dav Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an performed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျင 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 6, 201 32255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month Day, Year).

DHMH 17 Rev 7/2009

21014

BEL AIR, MD.

MACPHAIL ROAD

615 W.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 45 P M Jul <u>Satvabrata Rav</u> /Medical 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL 5A INT A
5. Social Security Number BALTIM OR E
If Under 1 Year | If Under 24 Hrs. AUNES 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Hours Min. Director <u>394-34-4097</u> 1/15/29 India Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Examination of the restriction of the content and the modical Examination of the content in the Modical Examination of the content in the modical Examination of the content in the modical Examination of the content in the modical Examination of the content in the modical Examination of the content in the modified of the content in the modified of the content in the modified of the content in th Director 1 ☐ Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 926 Regina Drive 21227 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Specify: ≥ Specify: 3 Widowed 4 Divorced Indian Completed 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) 12 Enviromental Engineer State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nirupama Pal ၉ Jasoda Kishore Bardhan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Shimanti Ray Ghosh / Daug. 2579 Corteland Drive Pittsburg, PA. 20b. Place of Disposition (Name of Ba temento remains the matter of the particle of the partic 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 7/9/10 Baltimore, Maryland 21. Signature of Funeral Service LC nsee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or shock, or heart failure. List of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** sure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð phenocarciami 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death.

1 ☑ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) eliered Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 / Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

rertificate be executed Box 68760. P.O. Satua brata Records, Vital Division of

show

Baltimore, Maryland 21215-0036

or Attending Physician: To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Ar completely filled in by the fu

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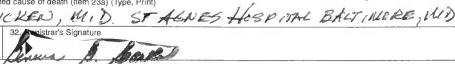
physician

attending

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HICKEN, WILLIAM J. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated

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Gururajan Ram	ach	1- For State	State of Maryla	Ce	rtificate of	Death	d Mental H		2 0 eg. No.	10 2178
Physic Medical Exam		Decedent's Name (First, Mi Gururjan R	ашаенанага	-				2. Date of Dear Month July 8, 20	th Day Year	3. Time of Death 1744 hrs
		4a. Facility Name (if not institu 4242 East West Hig		imber)		Chevy Cl Betherda	Location of Deat hase	h	4c. County of Montgom	
Funeral Director		5. Social Security Number 218-02-8950	6. Sex	7. Age (In yrs. I	last birthday) Yrs	Months Days				9. Birthplace (State or Foreign Country) Ethiopia
ý		Usual Residence of Decedent 10a. State 10b. Coun	tv.	I10c City	, Town or Locati	00			· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
Maryland 28a-f show a	tor		gomery			Chev	y Chase			1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Il Director	4242 East We	st Highway			10f. Zip Code 208]	15	11	og. Citizen of Wha India	t Country?
15-0036 filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	by Funeral	3 Widowed 4 C	Married Armed Fo	2 X No	If Ye	s Decedent of Hises, specify Cuban,			- 14. Race - White, A S Specify. I I	American Indian, Black, etc. sian- idian
21215-0036 ould be filed within 72 hours d Mental Hygiene. s marked other than "natur ic event, the Medical Exami	Completed t	15. Decedent's Education (S Elementary/Secondary (0-1)			during mo	est of working life.	DO NOT use ret		16b. Kind of Busi Softwar	ness/Industry ce Company
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21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medisa	Be (Padmaneri N	. Ramachand	lran				la H. Ra		
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LimC Page ment or tant: or oth		4 Donation 5 Other	Specify:	Cre	ntgomery	m, Inc.	20		Bethesd	a, Maryland
Ball permit Depart Impor		21. Signature of Funeral Service	ce Licensee	M0149	ZZ. IN	arrie arrio Address	of FacilityKOb Levy, Cha	ert A. H se _{de} Inc.	Pumphrey . 7557 Wi	Funeral Home/ sconsin Avenu
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D. BC t the der by the	Phy	Part II. Other significant cond	9011110		esulting in the ur	nderlying cause gir	ven in Part I.	23e. Did tol	bacco use contribu	ute to the cause of death?
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Records, P.O The law requires that to icate has been signed by page 2 should be detac	Completed							24a. Was a autops perform	sy prio	ere autopsy findings available or to completion of cause of ath? Yes 2 No
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Division ital or Attendii urs after death. ral Director: A	Certification:	3 Suicide 6 Co	estigation uld not be ermined (Specify)	of Injury - At ho	ome, farm, street	, factory, office bu	ilding, etc.	28f. Location (S or Town, St		or Rural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ledical C		Physician: To the best aminer: On the basis o and manner st	f examination ar						
F 3 F 3	N N	29b. Signature and title of certing		arou.		29c. License	number			(Month, Day, Year)
0		30. Name and address of person	n who completed called	Thu	232)	O.C.M	1.E. OCN	E	July 9, 2010	
The V		Theodore M. King, Jo		nt Medical E	200/	111 Penn Stre	eet, Baltimore	e, MD 21201		
St	ate	31. Data filed (Month, Pay Year	Jeneur 32. Reg	gistra is Signardi	re				<u> </u>	

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:55 AM ona ULY 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MOSPITAL OF BALTIMORE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Hi more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Force Completed by 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: Black 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Je. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) æ 17. Father's Name (First, Middle, Last) ဂ 19a. Informant's Name/Relati permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Katherine 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2010 ure of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death TRACT Pnysician/ IRINARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner RENA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Day Year Yes 2 No ed by the a detached f 1 ☐ Yes ≥ □ 9 ☐ Unknown P.O. I been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEMORRHAGIC STROKE, Division of Vital Records, DYS PHAGIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes 2 KN 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Impatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) death. Accident Accident Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuous Precisional To the passing of the cause of t (Check within 2 To the I the 29c. License number 29d. Date signed (Month, Day, Year) Nilen D 6495 Matel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

			1 - State Registrar	Pertificate of Death	Reg	N2010 21/90
	Physici		1. Decedent's Name (First, Middle, Last) James S. Stalnaker		2. Date of Death Month July 11	Day 2010 3. Time of Death 7:12 P M
-	/Medid Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	LAGIIII		3500 Chapman Rd.	Randa11stow		Baltimore
I	Funeral Director		5. Social Security Number 6. Sex XXX M 2 P 7. Age (In yrs. last birthd	Months Dave Hours Min	(Month, Day,	Year) 9. Birthplace (State or Foreign Country) 1959 Maryland
	put 🛊		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	f sho	o		allstown		1 ☐ Yes 🏋 🖫 No
	the N	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	h with	al D	3500 Chapman Rd.	21133		U.S.A.
9	ours after death with the Marylar ral", or items 23a or 28a-f show Examinar must be notified at	Funeral		3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ※ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
003	ural",	d by	3 Li Wildowed 4 Li Divorced Year or Dates:			Specify: White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examinat roust be notified at	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	king 10	6b. Kind of Business/Industry
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Baltimore, Maryland	es 1 and 2 should be filed vol Health and Mental Hygis fitem 27 is marked other rother traumatic event, It	To Be	James Albert Stalnaker	Helen	·	
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Σ	1 and 2 Health em 27 i		·	00 Chapman Rd. R	Randa11s	town, MD 21133
ore	Pages 1 ar nent of Hea int: If item		20a. Method of Disposition XIX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Di T.ake	sposition (Name of rematory or other place)		Oc. Location - City or Town, State
ţ	t. Pag tmen tant: njury		4 Donation 5 Other (Specify) Memor	ia? Park 🔝 🖊 👢		Sykesville, MD
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee			uneral Chapel P.A. vings Mills,MD2111
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68760,4	rtificate be executed ng physician and as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Lifter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
P.O. Box 68	eath cer attendir for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
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on	nding F th. : After e funera	ation	27. Manner Death 1	e of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	Edd. Boothbo Hol	injury occurred
Division of Vital Records,	il or Atter after dea I Director d in by the	Certification: To	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	t e, and due to the cau arred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	Vithin To th Comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
			V todan Bocken 20	H31615		7/12/10
	3		30. Name and address of person who completed cause of death (Item 23a) (The whole with the completed cause of death (Item 23a) (The whole whole whole who completed cause of death (Item 23a) (The whole whole whole whole whole whole whole whole who completed cause of death (Item 23a) (The whole who	pe, Print)	alto. n	21208
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Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010^{Year} July 9, James Ambrose Stiles. Sr 7:37 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Joseph Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 8, 1925 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Days Hours Min. Maryland 84 220-18-2987 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Timonium 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1504 Dulaney Valley Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 MaYes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) JJ Auto Supply Owner 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman C. Stiles Ann Marie Ambrose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Stiles-spouse 1504 Dulaney Valley Road-Timonium, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel and Cremation Ser. Pelair 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ARDIAC disease or condition resulting in death) Due to (or as a consequence of) reas Sequentially list conditions that y, leading to inimedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗙 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 X € R/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

or Attending Physician: The law requires that the death certificate be executed burial-tra P.O. Box 68760. physician the burial as attending Por þ signed b Division of Vital Records, page 2 s certificate

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72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 No 9 Unknow 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Adatural 5 Pending investigation

28a. Date of Injury (Month, Day, Year)

28c. Injury at Work? 1 □Yes 2 → No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Descritiging Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

29c. License number

29d. Date signed (Month, Day, Year)

2010

Parkelle MD

State Registrar

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Medical

MICHAEL 31. Date filed (Month, Day,

3 Suicide

29a. Certifier

4 Homicide

8109 HARFORD 1 32. Registrar's Signature

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ THEODORE SCARBOROUGH July Α. Ш 2:50 a M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 115 Bengies Road Middle River Baltimore Co. 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F (Month, Day, Year) Hours Country) Florida 219-32-3075 73 **Director** Sept. 26 1036 Jsual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 U.S.A. 115 Bengies Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electircal Engineer Vitro Labretories Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Thoedore A. Scarborough Jr. Rita Hyser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. O'Connell (Daughter) 335 Montrose Avenue, Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery July 14, 2010 |Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune I Service/Lice 2. Name and Address of Facility Name and Address of Facility McCully—Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ orona Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? by Completed 2₽No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed death? 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 🔲 Yes 5 Pending 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 7 State of Manyland Department of Health and Mental Hygiene Certificate of Death Red. No. 2 1 - For State Registrar 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 630 M Year **Physician** SCOT JAMIN O 201 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE RANDALLIT TUTURE CARES JLAWAJ my 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 36-451 271Director 30 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show Catansville r 28a-f she notified a MD 1 ☐ Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 15 marked other than "natural", or items 23a or any luluy or other traumatic event, the Medical Examiner must be a LISA 5723 Edmondson Avenue #CC9 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Back Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Government 12th grade NI 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21278 19a. Informant's Name/Relationship (Type. Print) Avenue # CC9 Catonsville MD Christne Randall-Scott (WIFE 5723 Edmondson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Owing Milb, MD Garrison Forest 20/200 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funcial 21. Signature of Funeral Service License andalutuwn MD 21133 728 Libert Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARCINOMA **Physician** disease or condition resulting in death) Medical Due to (or as a consequence of) examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and a be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unknown VASCULAR EMPHENAL 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 PNo Other: 2 ER/Outpatient 3 DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury/at Work? 27. Manner of De th 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

State Registrar

DHMH 17 Rev 1/2001

Medical

5400 OLD (TAZ MV 21133 0 M 31. Date filed (Month, Day, Year) 32. Registrac's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

3 ☐ Suicide

29a. Certifier

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4 Homicide

(Check only one)

29b. Signature and title of certifie

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

JULY

29d. Date signed (Month, Day, Year)

12,2010

Projection Death			4	For	State of M	laryland	d / Depa	rtment of F	lealth and	d Mental Hy		2010	21794
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Modical Examiner Modical Exa				shock, or heart failure. List or	complications that cause nly one cause on each li	ed the death ne.	h. Do not ent	er the mode of dyir	ng, such as card	diac or respiratory a	rrest,		Interval Between
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier (Dheck only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier (Dheck only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D0064100 July 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, M.D. 1500 Forest Glen Rd. Silver Spring, MD. 20910	of	ing Pl vfter tl unera	ate:	1x Natural 5 ☐ Pendin	g (Month, E	njury Day, Year)		wor	k?	ı	how inju	ury occurred	
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier (Dheck only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier (Dheck only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D0064100 July 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, M.D. 1500 Forest Glen Rd. Silver Spring, MD. 20910	ξ	after Direction by		4 ☐ Homicide determ						City or To	wn, Stat	te)	
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Smitha Bhikkaji, M.D. 1500 Forest Glen Rd. Silver Spring, MD. 20910											nuT.	y 0, 201	
				30. Name and address of person	who completed cause o	f death (Iten	n 23a) (Type, rest (Print) Blen Rd.	Silver	Spring, 1	MD.	20910	
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DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Physician/ 60 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COMMUNI NG Cet If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 24, 1956 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**X M 2 □ F Bountry) 212-72-4316 Director 53 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Annapolis 1X Yes 2 □ No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 695 Americana Drive 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 □ No <u>6</u> Maryland 21215-0036 1 x Yes 2 □ No Specify: White If Yes, Give Specify: Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Handyman Marina Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Enedelia Sasas Adam Sanchez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1865 Post Oak Trail, Reston, Virginia 20191 Krystol Sanchez Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest MD Vet. 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 7/13/2010 22. Name and Address of Facility Rurgee-Henss-Seitz Funeral Home, 3631 Falls Road, Baltimore, Mary 21. Signatura of Frineral Service Lice Ing. 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exam burial-transit resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part is 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 X within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No မ 1 Inpatient 2 IER/Outpatient 3 IDOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work' 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's State

Registrar

Physician /Medical ⊨xaminer in and ial-transit The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

al Hygiene. other than "

other traumatic event.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked ofth any injury or other traumatic event, once.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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Hospital or Attending Physician:

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3708 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar arko

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 20:08PM naela Medical 4a. Facility Name of not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayulew Medical Center HIMOre If Under 1 If Under 24 Hrs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2X F Months (Manth, Day, Year) 6 214-86-5215 44 **Director** Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director XXYes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 Diener Place Apt.#303 21229 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, et African Armed Forces?
1 ☐ Yes 2 🔀 No Completed by 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give d Mental Hygiene. marked other than "natural", Specify: American 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) South Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) NA Laundry 11th Grade Genera] Be 17. Father's Name (First, Middle, Last) Unk. 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Stella Tomlin permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is mark, any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 19a. Informant's Name/Relationship (Type, Print) 106 Diener Place Apt. #303 Baltimore, MD Stella Tomlin-Mother 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

t. Zion Cem. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 07-16-10 Lansdowne, MD Mt. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. Gilmor Street Baltimore, MD 21217 638 Ν. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Polymicrobial Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed immunode Human that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an i 24 hours after death.

e Funeral Director: After this certificate has be funeral director, page 2 s autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 No 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural injury 5 Pending 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signatu 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASIERA Poon timore, M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July 12 Physician/ Donald E. Tillery 2:00 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 550 Forest View Road Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 🔣 M 2 🗆 F Country)
Maryland Director 220-05-3798 88 8/8/1921 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Linthicum 1 🗌 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 550 Forest View Road 21090 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 X Married X Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give "natural" 3 Widowed 4 Divorced Specify. Completed White W 2 Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) I.T.O. Superintendant of Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Walter Tillery Christina Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lelia Mae Tillery (Wife) 550 Forest View Rd., Linthicum, Maryland 21090 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State Atlantic Crematory, LLC 7/13/2010 4 Donation 5 Other (Specify) Glen Burnie, Maryland 21. Signature of Francisco Service Licensee 22. Name and Address of Facility Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Immediate Cause (Final Inset and Death Ph_sician/ disease or condition resulting in death) WENTIG 15 W Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Lus to (or as a consequence of) attending physician and for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) Day 9 Unknown g Unknown been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q cate has been signated bage 2 should b 1 Yes 2 40 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 24 hours after death.

Funeral Director: After this certificate beted filled in by the funeral director, page Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 100 မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check з 🗌 within 2

To the I

comple 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Dr. Elliott Gorbaty 1411 Madison Park Drive Suite 2B Glen Burnie, Maryland 21061

32. Registrar's Sanature

30. Name and address of person who completed cause of the th (Item 23a) (Type, Print)

0200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 7 per fh g905 7-13-10 vt. State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July July 2010 MARY MICHAEL. TAYLOR 7:40 рм 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CR Care Group, LLC Laurel Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) VA Days Hours Min. 1 M 2 XX July 25, 1915 224-06-0717 95 94 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Laurel 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6103 Parkway Drive 20707 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ ¥o
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XXo Specify: 3XXWidowed 4 □ Divorced Specify: Caucasian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Grade 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Michael Mamie Goode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Taylor son 4307 Birmingham Place Beltsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3XX Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hebron Cemetery July 10, 10 Winchester, VA 21. Signature of Funeral Service Licensee ²Donardson funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
3 Years Immediate Cause (Final Advanced Dementia disease or condition

Physician/ Medical **Examiner**

Physician/

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending newscials. Box 68760 attending p P.O. I Records, Division of Vital completed filled in by the

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	resulting in death)	Due to (or as a consequence of):				
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	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Advanced Atherscler	rotic Cardiovas	ular Disea	ase	10 years
	resulting in death) Last	Due to (or as a consequence of): d.				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2★★No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ect 4 Pregnant at time of death 5 Oth 9 Unknown	copic pregnancy ner (specify)		23d. Date of de Month	elivery Day Year
	Part II. Other significant conditions co	ontributing to death but not resulting in the underl	lying cause given in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
•					•	S. I. I. SPSTILL.
3				1 □ Yes	2 LI NO 3 LI F	Probably 4XXUnknown
				24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of as 2XXNo
	25. Was case referred to medical examiner?		26. Place of Death (Chec	k only one)		
	1 ☐ Yes 2 XX No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Ho	ome 5 🗆 Residence	Other (Spec	_{cify)} Hospice
	27. Manner of Death XX Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	28d. Describe how it	njury occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street City or Town, St	and Number or Ruate)	ural Route Number,
	(Check 2 \(\subseteq\) Medical Examin	sician: To the best of my knowledge, death occur ner: On the basis of examination and/or investigation se Practioner: To the best of my knowledge, death	on, in my opinion, death occurred a	t the time, date and pl	ace, and due to the	cause(s) and manner stated.
	29b. Signature and title of certifier	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	29c. License number	29d.	Date signed (Mont	th, Day, Year)

D13671

Laurel Park Drive, Suite 102, Laurel, MD

July 8, 2010

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State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14201

B.G. Manegwala, M.D

31. Date filed (Month, Day

10-05123 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jose Dilma Saravia Villarreal State of Maryland / Department of Health and Mental Hygiene 2010 21800 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) Jose Dilma Saravia Villarreal 2. Date of Death Physician/ 3. Time of Death Month Day July 8, 2010 SARAVIA **Medical Examiner** VILLARREAL 2006 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Prince George's 5. Social Security Number 6 Sex If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MW/DD/YYYY) | 9. Birthplace (State or Foreign E. L. 7. Age (In yrs, last birthday) **Funeral** Days Hours Director 35 Country) SAL VADOR NONE 1 X M 2 F Yrs Usual Residence of Decedent YU. 10b. County 10c. City Town or Location 10d, Inside City Limits or 28a-f show 1 X Yes 2 No Riverda Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. VINCE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SALVADOR 6906 2073 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 1 Yes 3 Widowed 1 X Yes 2 No specify: A SALVABORIAN Specify LAU CASIAN 4 Divorced If Yes, Give Year ۾ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 CDNSTRUCTION ABORER 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be I LLARREAL SARAVIA JULIO MARIA ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20655 2710 Millseat Mechanics V. 1/e Adilio losses 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Important: If 1 X Burial 2 Cremation 3 Removal from State Moncag 2010 emetern Donation 5 Other Specify SALLIADO 22. Name and Address of Pacility 21. Signature of Funeral Service Licenses FUNERAL Hore & CELMATORY MILLER CUL Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or hear **Physician** failure. List only one cause on each line Retween Onset and /Medical Death Complications of Acute Appendicitis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical 1 per me g905 23a,27 per me the attending physician a ed for use as the burial -8-10 vt X UNPENDED AMENDED x The law requires that the death certificate be Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Ectopic pregnancy Day Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has been signed if director, nage 2 should be detailed <u>چ</u> Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? page ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other 1 Yes ٩ 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Yes 2 No within 24 hours after death.

To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined 4 ___ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 9, 2010

VEINE AMA

Reg. N.Z. U Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 10 ANNA ELIZABETH VOEGLEIN Ju /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner AIR ORIEN BeIAIR Bel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 TF Yrs Maryland 1923 Director 87 <u> 219–16–4150</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location fshow 10b. County Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Widden Events in at be muffled at once. 1 ☐Yes 2 XNo Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21014 1909 Emmorton Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No 2 Specify: White 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Administrative Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be Anna Maude Peters Henry Clay Lowe ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 550 Anchor Drive, Joppa, Maryland 21085 Joyce I. Brown / Daughter altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn <u>17-13-10</u> Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1∐Yes 2.2XTNo 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 □Yes 2 No 1 ☐Yes 2 ☐No certificate To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) ASS/STED Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred LIVING 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifie 29c. License number 045344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. UNION AVE, HAVRE DE GRACE, MD 21078 32. Registrar's Signature SURESH DHANJANI 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Please amend	Type or Print Item 30 p State of Ma	t in Black in er dvr g90 ryland / Depa	delible Ink. 35 7-13-1 artment of H	Ensure All VE lealth and Me	Copies Arental Hygier	e Legible. ne	
			For State Registrar			rtificate of l		Reg.	2010	21802
			1. Decedent's Name (First, Middle, Las	t)			2	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Sharon A. Walk	er				June 26	•	12:00 PM
and the same	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Death	
			14600 01d Orch		(1 t4 t4t-4t-4)	Cumber]		Date of Birth	Allegany	place (State or Foreign
ı	Funeral Director		213-54-3918	M 2 K F	(In yrs. last birthday) 60 Yrs.	Months Days	Hours Min	ept 26,	1949 Vir	ginia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryll f sho	힏	MD Allega	iny	Cumber1	and				1 □Yes 2X□No
	3a or 28a	al Director	10e. Street and Number 14600 Old Orchan	d Road		10f. Zip Code 21502			Citizen of What Cou USA	intry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Healith and Memlard Hygiene. The filem 271 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2⊠ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:	o	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🏻 No	ispanic Origin? (Spec in, Mexican, Puerto Ri Specity:	ify Yes or No- can, etc.)	14. Race - Amer Black, White Specify: Wh	
5-0	72 hor	eted	15. Decedent's Ed	ucation de completed)	(Give	dent's Usual Occup	during most of working		. Kind of Business/I	ndustry
21215-0036	d within giene. rr than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life	DO NOT use retired	()		chemical	company
Maryland	12 should be filed within h and Mental Hygiene. r is marked other than "traumatic event, the Mental traumatic event, the Mental traumatic event the Mental traumatic event the Mental traumatic event the Mental traumatic event the Mental traumatic event the Mental traumatic event the Mental traumatic event the Mental traumatic event the Mental traumatic event the Mental traumatic event the Mental traumatic event the Mental traumatic event the Mental traumatic event the Mental traumatic event traumatic event the Mental traumatic event event	To Be C	17. Father's Name (First, Middle, Last) Randolph Hamilto	n Redman			18. Mother's Name (First, Middle, Maid ce Puffe	den Surname) nbarger	
lary	2 shou and N is ma		19a. Informant's Name/Relationship (7				and Number or Rural			
	and and m 27		Robert Walker -	husband			cahrd Road			
Baltimore,	0 U - =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify		20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	Da	te 200	c. Location - City or T	own, State
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Euleral Service Licen	Naylot /	2		ss of Facility natomy Boar ce, Marylar		V. Baltimo	ore Street
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused tone cause on each line	the death. Do not en				,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	PAN		ne c	Aneco	7		Onset and Death
ز	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
	Exammer	<u>.</u>	Sequentially list conditions,	b	acrosquence of:			<u>. </u>		
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	execu	xar	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
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99	rtifica ng ph as th	/ledi								
O. Box	he death certificate be executed r the attending physician and shed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	у		23d. Date of del Month	ivery Day Year
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Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed						24a. Was an autopsy performe	d? death?	topsy findings available completion of cause of
Vital	sician: The certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Death		No 1 ∐Yes	2 🗆 110
Ž	Physician: r this certific ral director, I	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	nt 3 DOA Oth	er.		ce 6 □Other (Spe	cify)
on of	ng ifte	tion: 1	27. Manner of Death 1 A Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time (Year) Injury	Wor	ry at 2 k? Yes 2 □ No	8d. Describe how	injury occurred	
Division	Il or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, st . (Specify)	reet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) Check only one)	ysician: To the best of niner: On the basis of and manner sta	examination and/or i	th occurred at the ti nvestigation, in my	me, date and place, a opinion, death occurre	and due to the cau	se(s) and manner a and place, and due	s stated. e to the cause(s)
	To the Within To the compl	Me	29b. Signature and title of certifier	0 1.		29c. Licens	se number	29d	I. Date signed (Mont	h, Day, Year)

State Registrar

904 Seton Dr. #202 Cumberland, Md. 21502 Alida Podrumar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2:58PM 10 Donna J. Wienecke 4a. Facility Name (If not institution, give street and number) 4c. County of Death Rosedale Baltimore Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 16, 1955 Social Security Number 7. Age (Inlyrs. last birthday) Birthplace (State or Foreign Country) 220-66-0085 1 M 2 3F 54 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₩ No MD Baltimore Nottingham 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10 Bryce Court 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ∐Yes 2X If Yes, Give Year or Dates: 2**X** No 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Dance Instructor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Wienecke Edna V. Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Wagner /friend 10 Bryce Court Baltimore MD 21236 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Bayview Crematory 7/12/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Parkinson's Advanced Due to (or es a consequence of):

Physician /Medical Examiner

certificate be executed

of Vital Records, P.O.

Division or Attending

To the Hospital

cal

State

29b. Signature and title of certifier

Dr. Nigan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin

Physician

/Medical

Examiner

Director

Funeral

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modes! Examinat maint to molified at

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with the Maryland

Baltimore, Maryland 21215-0036

page 2 should

nding physician and use as the burial-transit Exami Physician/Medical ğ Completed has certificate Be Certification: To After this within 24 hours after death.

To the Funeral Director: After the funeral py the fur

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immunicate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ Ño 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1∐Yes 2√ZNo 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

Kes 0000

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 8:24 AM WOODEN JERicho LEROY 2010 \mathcal{T} \cup l \vee 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 7601 OSJERDA BALTIMORE St. JosEph Medical CENTER Tawson Count Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Hours 2 2010 July 6 MAR PLAND NONE Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b, County 1 Yes 2 No BAIT more MARYLAND PARKNILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21234 U, S. A. YAKONA 1861 RoAd Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Infant NONE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William APRILLE Virginia MAE HAMILTON ucas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mother Acille Visginia Me Hamilton

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) 1861 PAKONA ROAd PARKVILLE, Md. Date 20b. Place of Disposition (Name of Evans Function of the place) Evans Function Chapel and Cremation Serv. Inc Reaceful Alternatives Funeral + Cremation Center, Pareaceful Funeral Funer 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death h. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respirator distress Due to (or as a consequence of Due to (or a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MELORMANICAL 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death Month Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No autopsy performed? Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No M 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760, signed by the a Division of Vital Records, P.O. has e 2 page certificete director, this After thi death. within 24 hours after death.

To the Funarel Director: A

Physician

/Medical

Examiner

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Director

Funeral

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Physician/Medical

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Certification:

Medical

State Registrar

Funeral

Director

other then "natural", or items 23s or 28s-f show vent, the Modical Examinar must be multipled at

the Maryland

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f Health a Item 27 I

permit. Pages Deportment of I Important: If its any injury or o

Physician /Medical

Baltimore, Maryland 21215-0036

IE FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated.

29b. Signature and title of certifier

29c. License number 00060495

TOWSON

29d. Date signed (Month, Day, Year)

MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE

ZHEN FAN 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Valentine Waddill Dial 9:55pM June **2010** Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death
Montgomery 4c. Manor Care Nursing Center Chevy Chase 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** Months Days Hours 9/20/1907 **Director** 579-60-6304 102 Florida Usual Residence of Decedent fshow 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No DC N/A Washington 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United 1626 Decatur St. States 2001 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 XWidowed 4 Divorced Completed Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles A. Dial Jerenia Valentine 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Hammond Hedgepath 8230 West Beach Terrace, NW Washington, DC 20012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery | 06/14/2010 | Washington, DC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, D.C. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Myocardial Infarction disease or condition Medical resulting in death) Examiner Atherosclerotic Heart Disease Grown field lict or different, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Hypertension sician and burial-trans Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ cate has been signed by the atter page 2 should be detached for u in the past 12 months? Month Year Day Pregnant at time of death Yes 2 🔽 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Osteoarthropathy, Failure to Thrive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed?

1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: မြ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) nours after death. neral Director; After the filled in by the funeral Certificate: 27. Manner of Death 28c. Injury at work? 1 □ Yes 2 □ No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated eartifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) June 10, 2010

/ DV State

DHMH 17 Rev 7/2009

Registrar

Dr. Raman

31. Date filed (Month, Day, Year)

Tuli

10810 Darnestown Rd. suite 202 Gaithersburg, Md 20878

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Maryland	/ Department of Health and Certificate of Death		2010	21806
		1. Decedent's Name (First, Middle, L	ast)	/ / //	Reg. 2. Date of Death		3. Time of Death
Physic Med		forothy 1	Hedrick ,	Waller	Jone 13	Day 2010	1937 M
Exam	iner	4a. Facility Name (if not institution, gi	omnrial Hos	4b. City, Town, or Location of Deal	th	4c. County of Death	
Funera Directo		229-24-2483		birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthpl. Countr	ace (State or Foreign ry) Virginia
aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Location		10	0d. Inside City Limits
vith the Ma 23a or 28a st be notii			Ave Art 6	10f. Zip Code 2/2/8	10g.	Citizen of What Count	/ \
tore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by Funeral		12. Was Decedent Ever in U.S. Armed Forcee? 1	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - America Black, White, et Specify:	
Maryland 21215-0036 2 should be filed within 72 hours after tith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed by			16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking 16b	Motel	ustry
yland Id be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Las	Plarence h	Pedrick 18. Mother's Na	me (First, Middle, Maide	en Surname)	
Mary nd 2 shoul salth and I n 27 is me er traums		19a. Informant's Name/Relationship Tames E.	(Type, Print) Son	19b. Mailing Address (Street and Number or R 4330 Mairgold	ural Route Number, City	og Towy, State, Zip Co SCICAMP	4721017
altimore, mit. Page 1 and partment of Heal portant: If item 3 y injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State	ce of Disposition (Name of netery ergmatory or other place)	Date 20c	Location City or Tov	yn, State
Baltimo	i ci	21. Signature of Juneral Pervice Le	Mlw	325 Church St	Grubb P	Virginia	24382
Pnysician	v i	23a. Part 1, Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition		Do not enter the mode of dying, such as cardia	c'or respiratory arrest,		Approximate Interval Between Onsetiand Death
Medica Examine	r	resulting in death)	Due to (or as a consequer	nce of):			Lweck
uted uted ansit	Examiner	if any, leading to immediate Cause (Disease or iinjury that initiated events	Due to (or as a consequer	nce of):			
760 (sq. sate be executed physician and the burial-transit	dical E	resulting in death) Last	Due to (or as a consequer	nce of):			
6876 ertificat ding ph	/Mec	IF FEMALE:	23c. If yes, outcome of pregnance	ev		20 d Data of dalling	
be death certificate death certificate y the attending properties of ched for use as it	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 Fetal of 4 Pregnant at time of dea	death 3 Dectopic pregnancy		23d. Date of deliver	Day Year
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the but			contributing to death but not result	ing in the underlying cause given in Part I.		2 No 3 Prob	M
Division of Vital Records, lat or Attending Physician: The law requires rs after death. In Director After this certificate has been signed in by the funeral director, page 2 should be the built by the funeral director, page 2 should be the funeral director.	Completed by				24a. Was an autopsy performed 1 Yes 2	prior to com death?	sy findings available inpletion of cause of
Vital rsician s certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	26. Place of Death (Chi	eck only one) Home 5 Residence	6 Other (Specify)	
on of nding Phyath.	Certificate: 1		28a. Date of injury (Month, Day, Year)	8b. Time of injury at work? M 1 \sum Yes 2 \sum No	28d. Describe how in		
Division and an arrangement of the properties of				e, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural i ate)	Route Number,
Division of Vital Reconstruction of Vital Reconstruction and the Hospital or Attending Physician: The law within 24 hours after death. The the Funeral Director After this certificate has completed filled in by the funeral director, page 2	Medical		miner: On the basis of examination a	dge, death occured at the time, date and place, and/or investigation, in my opinion, death occurred nowledge, death occurred at the time, date and p	at the time, date and pla	ace, and due to the caus	se(s) and manner stated.
To t with To th		29b. Signature and title of contifler	lyni	29c. License number AT - 2438		Date signed (Month, D	2010
4		30. Name and address of person wh	o completed cause of death (Item 2		ersty Pkwy B	altimore MI) 21218
Si Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	pares			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mar Registrar		artment of F tificate of D			giene Reg. No. 20	10	21807
	DI		Decedent's Name (First, Middle, Last)				2. Date of Dea	th		3. Time of Death
	Physicia Medic		Jacquelyn Williams-Le	vai				0, ^{Day} 2010) Year	9:50 PM
	Examin	ier	4a. Facility Name (if not institution, give street and number) Casey House		4b. City, Town, or Rockvil	Location of Death			y of Death gomery	7
	Funeral Director		5. Social Security Number 6. Sex 7. Age (l	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Mar. 23	Year) 1948		lace (State or Foreign ry) ginia
	d tow	_	Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or Loc	ation	-			1	0d. Inside City Limits
	arylan a-f sh fied a	읞							"	1 X Yes 2 No
:	or 28; notil	ä	MD Montgomery 10e. Street and Number	Takoma Pa	10f. Zip Code			10g. Citizen of	What Coun	
	23a o	Funeral Director	7805 Lockney Avenue, Apt.	201	20912	-7436		USA		-,-
;	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Rick Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)								ce - America	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	The local forms of the local for							ck, White, e	
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and	be file sntal l- ked o c eve	일	Harry Samuel			18. Mother's Nan	Blackwe Black		ie)	
<u></u>	ould he mark	1 8	19a. Informant's Name/Relationship (Type, Print)	19h Mailin	g Address (Street a				State Zin C	inde)
Ĕ	althau althau 27 is artrau		Ivy Fairchild - Sister	1	x 34, Lo				o.a.o, 2,5 o	,
ē,	1 and of Hea item	1 3	20a. Method of Disposition	20b Place of Dispos	sition (Name of	1	Date	20c. Location	- City or To	wn, State
<u>ء</u>	Page nent d ant: If ury or		1 XX8 yria 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ ponation 5 ☐ Other (Specify)	Zion Bant Church Ce	ist emetery	7-17	-2010	Lottsh	ourg,	VA
Baltimore,	permit. Page 1: Department of I Important: If its any injury or of		21. Sign ture of Funeral Service Linnsee	22	Name and Addres	is of Facility $^{\dot{B}}$	erry O.	Waddy I	Tunera	1 Home
п	<u> </u>		Jane Moore	- 6	784 Mary	Ball Ro	ad, Lanc	aster,	VA 2	22503
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between
P	nysician/ Medical	V 1	Immediate Cause (Final disease or condition resulting in death)						4	Onset and Death
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		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a c	onsequence of):						
ţ	d ansit	Examiner	cause. Enter Underlying Cause (Disease or initipity that initiated events c			_	_			
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ă 🧃	the ched	ysi	1 Yes 2 X No 9 Unknown 9 Unknown	ine or death 5	Other (specify)					
ָ כ װְ	ned by deta	by PI	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to the	e cause of death?
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of Vital Records,	is bee	Completed					24a. Was a		Were autop	sy findings available npletion of cause of
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	this c	은		2 ER/Outpatien		4 ☐ Nursing H	ome 5 Reside			Hospice
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SIOIS	deatl ctor: y the	Ψįįį	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury	- At home, farm, stre		res 2 🗆 No	28f. Location (St	reet and Numb	er or Bural	Route Number
DIVISION Palor Attendir	after Dire		4 Homicide determined 200. Place of injury building, etc. (3		,,,		City or Town		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	leate Hambon,
]	to the hospital or Attending Frigstone. The law requires that the locality cate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	29a. Certifier 1 Certifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of examiner)	knowledge, death o	ccured at the time,	date and place, a	nd due to the cau	se(s) and man	ner as stated	d.
Ho H	une n hin 24 the Fi	Me	unly that 3 2/Certifying Nurse Practioner: To the be		with behind of the	time, date and pla	ce, and dust to the	nause(s) and m	enner es ste	tod.
اِ	S 5 ≨ 5		29b. Signature and title of certifier	Ance	29c. License	_	- 1	9d. Date signe		ay, Year)
			· Diene Kucher	T CMM		115108		7-12	-10	
			30. Name and address of person who completed cause of deat Diane Ruckert, CRNP 60	th (Item 23a) (Type, P. 01 Muncast		Road, Ro	ckville,	MD 20	0855	
	Stat	e	31 Date filed (Month Day Year) 33 D intraria		bank)					
	Registra	ar	JUL 13 2010 Kenew	n p. 19						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Mildred ASH Elise 8:05 P. J<u>une</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 14510 Homecrest Rd Silver Spring Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JUne 29, 1 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs **Funeral** Hours 065-05-0660 1 🗆 M 2 💢 F Months Director lllne 910 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Montgomery 10a. State Md. 10c. City, Town or Location Silver Spring 10d, Inside City Limits Director 1 Tes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 14510 Homecrest Rd. 20906 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 N Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) home Homemaker own Be 18. Mother's Name (First, Middle, Maiden Surname) Harriet Hahn 17. Father's Name (First, Middle, Last) Jacob Israel 19a Informant's Name/Relationship (Type, Print)
Sheila Gan / daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90064 10571 Northvale Rd., Los Angeles, CA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Rest Haven Member Park June 24,2010 Evendale, Ohio 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Qther 22. Name and Address of Facility Torchinsky Hebrew Funeral Home, Inc 21. Signature of Funeral 254 Carroll St., NW, Washington, DC 20012 23a. Part . Enter the disease, o comp cation shock, or heart failure. List only one caus hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, o complications Approximate Interval Betw 4 Onartona Phys Immediate Cause (Final Congestive Heart Failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 2 years Atherosclertic Heart Disease Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Live Great as Pregnant at time of death Ectopic pregnancy in the past 12 months? Day Month Year 1 ☐ Yes 2 🔀 No 9 ☐ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> Chronic Renal Failure 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XVo After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Certificate: To 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? within 24 hours after death.

To the Funeral Director; Aff
Completed filled in by the fur 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 6 29d. Date signed (Month, Day, Year) 0009748 2010 June 22, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Weinstock, MD, 10313 Georgia Ave., Silver Spring, Md 20902

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 21809 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month REGINO ARGUETA 2010 June 12:20 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, April 6, 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 X M 2 D F Months Days Director 099-46-1310 63 Guatemala 28a-f shov 10a. State 10b. County traumati: event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 X No 6 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 10306 Georgia Avenue 20902 U.S.A. and 2 should re filed within 2 hours after death vit Health and Mental Hygiene.
Item 27 is man ed other that "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 0. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 🕱 Yes 2 🗆 No Specify: Guatemalan Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Felipe Argueta Cristina Aguirre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17700 King William Court, Olney, Maryland 20832 Marlyn A. Zavala/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 separtment of H Important: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Ceme. Silver Spring, Maryland 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the dise se, o shock, or heart failure. List o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Interval Between Onset and Death Immediate Cause (Final Glioblastoma Multiforme Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hemorrhagic Cerebrovascular Accident 1-2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): pnysician and the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes ∠ ⊑ □ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Type 2 Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 X No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No After 1 Natural 5 Pending Accident s after death. Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined filled in 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 7/2009

State

D 0065485

1500 Forest Glen Road, Silver Spring, MD 20910

RSM

MD,

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara Ann Supanich,

JUN 28

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		rtificate of De			Reg. No 2 0 1 0	21810			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea _Month		3. Time of Death			
	Medic	al	James E. Adams 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ocation of Death	June	26 2010 4c. County of Dea				
	Examin	er	Larkin Chase		Bowi			Prince (
Ī	Funeral Director			(In yrs. last birthday) 86 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day May 19	9. Bi (, Year) 1924 Mai	Year) 9. Birthplace (State or Foreign Country) 1924 Maryland			
	nd now at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits			
	larylar 3a-fsh ified	ecto	MD Prince Georges	-	owie				1 ဩ Yes 2 ☐ No			
	the M	١	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?			
	h with	Funeral Director	12921 Cherrywood Lane		20715			USA				
336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 15. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Specify Cuban, Mexican, Puerto Rican, etc.) 10. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)										
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/lan	d be fi Vental arked ttic ev	욘	Henry Adams, Jr.			Mary W	right					
Nan	should and the raums		19a. Informant's Name/Relationship (Type, Print)		•			r, City or Town, State, Z	ip Code)			
e,	and 2 Health tem 27		Lillian E. Adams / Wife 20a. Method of Disposition	20b. Place of Dispo	1 Cherrywoo	T	Bowle,	MD 20715 20c. Location - City of	r Town, State			
Baltimore, Maryland 21215-0036	Page 1 rent of rut: If ii		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cre	matory or other place)	1		Brentwood				
3alti	permit. I Departm Importa any inju	21. Signature of Funer Sayly Licensee 22. Name and Address of Facility Fort Lincoln Funer 3401 Bladensburg Rd. Brentwood, MI										
ш	ēΩ ≟ a ol	Н	23a. Part 1. Enter the disease, or complications that caused to						20722 Approximate			
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Ĭ	Physi r this c ral dire	은	1 ☐ Yes 2 XO No 1 ☐ Inpatier 27. Manner of Death 28a. Date of injury	nt 2 ER/Outpatie	ent 3 L DOA			dence 6 Other (Spe	ecify)			
o uc	nding ath. r: After e fune	icate	1 🛣 Natural 5 □ Pending (Month, Day, 2 □ Accident Investigation	Year) injury	work?	es 2 🗆 No						
Division	al or Atte s after de: il Director ed in by th	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? N M I Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred										
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_	Vith Voir Con		29b. Signature and title of certifier The to a second sec	MD.	29c. License n			29d. Date signed (Mon				
	4+1		30. Name and address of person who completed cause of dea		D00514	+3/		6/29/201				
1			Okeowo Darly Ibitoye 12200			e 232 G	lenn Da	le, MD 207	69			
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar	's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar	iai yiai i	-	tificate of L		a Mentarriy	Reg. No	2011	21811	
	Physicia	an/	Decedent's Name (First, Middle, Last) Mary Lou	ı Amat	ucci			2. Date of De Month		ay Year 2010	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give street and number)			4b. City, Town, o	r Location of De	July eath		c. County of Death	3:55 P M	
			Somerford Assisted Living 5. Social Security Number 6. Sex 7. A	ge (In yrs. Ia	nt hirthday)	Ha If Under 1 Year	gerstov			Washir	ngton lace (State or Foreign	
	Funeral Director		577-36-7530 1□M2⅓F	86	Yrs.	Months Days		Min. (Month, Da OCt. 3)	ay, Year) Country) 1, 1923 California			
	show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	Location 10d. Inside City						
	Mary 28a-f notifie	Jirec	Maryland Montgomery			Silver Sp	ring				1 Yes 2 X No	
	with the 23a or	Funeral Director	10e. Street and Number 14715 Lindsey Lane			10f. Zip Code 209	06		10g. Ci	itizen of What Coun $U.S.A.$	try?	
350	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Armed Forces' 1 Yes 2 X 1f Yes, Give Year or Dates.	?		Was Decedent of H f Yes, specify Cuba □ Yes 2 🔀 No		R (Specify Yes or No- uerto Rican, etc.)		14. Race - America Black, White, e Specify: Whi	etc.	
9500-CLZ	"natura dical E	plete	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	dent's Usual Occup	ation	warkina	16b. F	Kind of Business Inc		
777	vithin 73 jiene. er than the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 4	· 5+)	life. D	0 NOT use retired) Iomemaker				Home		
yland	e filed v ntal Hyg ed othe event,	To Be	17. Father's Name (First, Middle, Last) Edward Cook					Name (First, Middle, aude Shep)		•		
aryie	nould b ind Mer s mark umatic		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street		r Rural Route Numbe			ode)	
_	이는 등 등		Richard C. Amatucci (Son)		4440	Willard	Ave. Ui	nit 1511 (Chev	ry Chase,	MD 20815	
HOLE	age 1 a ent of H nt: If ite y or ott		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	te Ce	emetery, cren	sition (Name of natory or other plac rg Cremat	oru Ji	Date uly 9, 2010	l	_ocation - City or To fmithsburd	wn, State r, Maryland	
Баітіто	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once,			MO 141	4 22	. Name and Addre	ss of Facility	J.L. Da	avis	Funeral	Home	
n	89 E # 9		Jether Lee Davis					ve. Smith		g, Maryla		
1	nysician Medical	0.1	23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lis Immediate Cause (Final disease or condition resulting in death) Due to (or as	Sto	loke	er the mode of dyin	g, such as card	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death	
	Examiner	L		1/4	post	ou 5,51						
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unideallying Cause (Disease or linjury	s a conse 🅼	fice of):	= -				- 1		
	execut ian and irial-tra	e Exa	that initiated events c. — Due to (or as	s a consequ	ence of):						<u>-</u>	
00/90	cate be physic the bu	Medical	d									
DOX 00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23c. If yes, outcomed in the past 12 months?	n 2 🗀 Fetal at time of d	Ideath 3 ☐	Ectopic pregnand Other (specify)	Çy		ł	23d. Date of delive Month	ory Day Year	
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ras,	equires een sig nould b		Dementia					_ 1 🗆		V.	pably 4 Unknown	
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VITAI H	ian; Tr ertificat ctor, pa	BeC	25. Was case referred to medical examiner?			26. P	ace of Death (0	1 L Yes Check only one)	2 12	No 1 ☐ Yes	Assisteā	
5	Physic this ce ral dire	ျ	I Hospital:		ER/Outpatier 28b. Time of	nt 3 DOA Oth	4 L Nursin	ng Home 5 Resid				
on or	ending sath. or: After ne fune	ficate	1 Natural 5 Pending (Month, D	ay, Year)	injury	work			iow injui	ny occurred		
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5	Hospita 4 hours Funeral ted fillec	Medical	29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of	of my knowle	edge, death of and/or invest	occured at the time	, date and place	ce, and due to the ca red at the time, date a	ause(s) a	and manner as state e, and due to the cau	d. use(s) and manner stated	
	To the within 2 To the comple	ž	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	e best of my	knowledge, o	death occurred at the		d place, and due to th	-	(s) and manner as sta ate signed (Month, L		
			I havid ahmood	-M	1	Do	062	333		7-7-1	0	
			30. Name and address of person who completed cause of Shahi'd Mahmed	death (Item			A	ممملا م	· /- i-	raise man	21742	
	Sta			trar's Signat		VITTIET!	1110	- ireige	1 271 (July 1110	allys	

Registrar

O DHMH 17 Rev 7/2009

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ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 06/ Day 28/2010 Physician/ Michael Scott Burlingame 11:55 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Lothian 6300 Mallard Lane If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **x** XM 2 □ F Hours 0470171962 WA Director 532-72-9637 48 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination 2. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Lothian 1 🗆 Yes 2 🎦 No MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 20711 6300 Mallard Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No þ 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Beth Russakoff Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6300 Mallard Lane, Lothian, MD 20711 Mary Hulbert/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Lee Crematory ☐ Burial 2XXCremation 3 ☐ Removal from State 6/29/2010 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign are f Funeral Service Live 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Md Blvd., Owings, MD 20736 Lisa M. Mauris 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CarcinomA Kectal Physician/ 005 disease or condition Medical resulting in death) Examiner recto-Colon CarcinomA metastatic if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine 2010 Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and resulting in death) Last attending physician Physician/Medical 2010 Division of Vital Records, P.O. Box 68760 the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ☐ Live Birtn ∠ ☐ Total acc in the past 12 months? Month Dav Year Yes 2 No the be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 After this certificate 1 Yes 2 No 1 🗆 Yes within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 1 Yes 2 No ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29d. Date signed (Month, Day, Year) Signature and title of ce D042049 executical Name and address of person who completed cause of death (Item 23a) (Type, Print) Maribovo. MD. JRW) 15 32. Registra s Signature 31. Date filed (Month, Day. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month SANFORD **BERNS** 11:18 PM June 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Hours Min. (Month, I Day, Ye Director 91 498-03-9611 Baltimore, MD Usual Residence of Decedent shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery Germantown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20400 Apple Harvest Circle, Apt #L 20876 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. ģ 1 Never Married 2 Married WW Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired College (1-4 or 5+)
2 Years Elementary/Seconday (0-12) Entrepreneur Business is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Ben Berns Frieda Simon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth a Important: If item 27 is any injury or other tran Linda Berns/Daughter 6102 Dunleer Court, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State metery, crematory or other

Hamedrosh 06/29/ 1 Burial 2 Cremation 3 X Removal from State Beth" Saint Louis, MO 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licersed 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. MO #1070 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the duease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fall re. List only one cause on each line. Interval Between Onset and Death Nour Immediate unuse (Final <Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examin or Attending Physician: The law requires that the death certificate be executed after death. and -tran Due to (or as a consequence of): inding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ō in the past 12 months? Pregnant at time of death Unknown 2 No the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Hypertension 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? certificate Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🔀 No Other: ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 X ER/Outpatient 3 IDOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury thours after death.

uneral Director: Afted filled in by the fur 1 Yes 2 🗆 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Hospital 24 hours Funeral Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) June 26, 2010

Registrar
DHMH 17 Rev 7/2009

State

Center Drive, Rockville, Maryland 20854

9901 Medical

e and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event; the Meaonee. 21. Signature of Funeral Service Licens Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has by page 2 s this certificate 25. Was case referred to medical examiner?

1 Yes 2 No eral Director: After this certific filled in by the funeral director, Be ၉ 27. Manney of Death Certificate: 1 Natural 4 Homicide To the Hospital within 24 hours To the Funeral I Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Milan- MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARIM. 7010 CARROLL AVE, STE 340, Taken MOBARAK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 3 0 2010 Registrar DHMH 17 Rev 7/2009 ORIGINAL

Physician/

Medical

Examiner

Funeral

Director

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be filed within 72 hours after death with the Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** William Roscoe Brock, Sr. 27, 2010 5:45 A. M June /Medical 4a. Facility Name (If not institution, give street and number) Center 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Thomas More Nursing & Rehabilitation Prince Georges **Hyattsville** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months 1 X M 2 □ F 85 March 29,1925 Washington, D.C. 578-22-3837 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XYes 2 □ No Directo District of Columbia Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20011 United States 1301 Upshur Street, N.W.; Apt. 406 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Aug. 1943 1 Xives 2 No If Yes, Give April 1944 Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗶 No Specify: Black à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Spector Freight Elementary/Secondary (0-12) **12th grade** College (1-4or 5+) Truck Driver Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Alfonzo Brock-Smith Mildred Virginia Martin ၉ 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Nadine Brock-Harris 1421 Staples Street, N.E.; Apt. 4; Washington, D.C. 20002 $\mathbf{July}^{\text{Date}}_{\mathbf{27,201}}$ 0 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Arlington, Virginia Arlington National Cemetery 21. Signature of Funeral Service I 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001] 23a. Part 1. Enter the disease, or complications that consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Antenoscloudic Candiarasul 10005 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No 9 Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ en Disans 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Dementta 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Division of Vital Records, P.O. Box 68760, director or Attending 24 hours after deat Funeral Director: filled in by within 2

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If item 27 or other t

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Examiner

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Maryland 21215-0036

Itimore,

State Registrar

4203 Queaus sury and Hysteville Mis

and address of person who completed cause of death (Item 23a) (Type, Print)

		- State Registrar				Cei	tificate d	of Death		Reg. No.			
		1. Decedent's Name (First, Mic	ddle, Last)			,	` .	4.4	2. Date of De			3. Ti	me of Dea
Physician		Lois Eli	nira			t	brese	cker	July	C8 Day	2010		10 A
/Medical Examiner		4a. Facility Name (If not institu	tion, give s	street and number)			4b. City, Tow	n, or Location of Dea			County of Deat	:h	
Examine		The Johns Hopki	ns Ho	spital			Baltimo	ore City			Baltin	nore	
Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs.	last birthday)	If Under 1 Y			rth	9. Birl	thplace (S	tate or Fo
Director	- 1	195-28-0164	.1 _	M 2 💢 F	74	Yrs.	WOITING	ays Hours Will	01 2	23 19:		Lio	n, P
MO 4		Usual Residence of Decedent 10a. State 10b. Cou	nty		10c. Cit	y, Town or Lo	cation					10d. Ins	ide City L
and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at To Be Completed by Finneral Director	ğ	PA Fran	ıklin		Wa	ynesbo	ro					1X	Yes 2
or 28a-f sl	<u> </u>	10e. Street and Number			T	<i>y</i>	10f. Zip-Co	de		10g. Citiz	en of What Co	untry?	
tal Hygiene. d other than "natural", or items 23a or 28a-f show svent, the Medical Examiner must be notified at Be Completed by Filneral Director	ᇹ	220 W. Sixtl	St.				17:	268		1	JS		
or items 23a liner must b	ner	11. Marital Status		12. Was Decedent	Ever in U.	S. 13.	Was Decedent	of Hispanic Origin? (Cuban, Mexican, Puer	Specify Yes or No)- 1	4. Race - Ame		an,
or its	2	1 Never Married 2	arried	Armed Forces? 1 Yes 24 If Yes, Give	No		il res, specily t 1 ⊡ Yes 2 🛣		to Alcan, etc.)		Black, White	e, etc. whi	+0
ral", o Exam	5	3 Widowed 4 Divorc	ed	Year or Dates:			ı ⊟ ies ∠∧	No Specify.			Specify:	WIIT	Le
ygiene. In the Medical E.	erec	15. Dece (Specify only hig	lent's Edu hest arade			(Give	dent's Usual O kind of work d	one during most of we	orking	16b. Kir	d of Business	/Industry	
Mec Mec		Elementary/Secondary (0-1		College (1-4 or	5+)	life.	DO NOT use re	etired)	J				
ygier the	3	10				hom	emaker		/=:		own ho	me	
d off	ا <u>ت</u>	17. Father's Name (First, Midd Guy S. Se	. ,	Cr.					ame (First, Middle a E. Pau		Surname)		
of Health and Ment item 27 is markec other traumatic e													
and is made and aum	1	19a. Informant's Name/Relatio						treet and Number or F			Town, State, 2	(ip Code)	
된 다 ㅋ		Arthur W. Bie	seck	er				n St. Way			17268		
Department of Heal Important: If item 2 any injury or other once.	2	20a. Method of Disposition 1 XBurial 2 ☐ Crematic	n 3∏R	emoval from State	20b. F	Place of Dispo emetery, crea	osition (Name of matory or other	place)	Date		ation - City or	Town, Sta	te
ant: I		4 Donation 5 Other	(Specify)		Par			ai Gara.	12, 201	Char	nbersbu	rg,	PA
port y inj		21. Signature of Funeral Service	e License	9		22	2. Name and A	ddress of Facility G	rove-Bow	erso	k Funer	al H	ome,
Importa any inji once.		6 Jauss	11	love Now	0	5	0 S. B	road St.	Waynesbo	ro, l	PA 172	68	
	1	23a. Part 1. Enter the disease, shock, or heart failure. Li	or complicest only one	cations that caused cause on each li	d the death ne.	n. Do not ent	er the mode of	f dying, such as cardia	c or respiratory a	arrest,		Interva	ximate al Betweer
ysician		Immediate Cause (Final disease or condition		leuken								Onset	and Deat
Medical		resulting in death)		Due to (or as		uence of):							
aminer		Sequentially list conditions	h h										
	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Į	Due to (or as	a consequ	uence of):							
ician and burial-transit cal Examiner	8	Cause (Disease or injury that initiated events	c								-13		
		resulting in death) Last		Due to (or as	a consequ	uence of):							
ding physician and use as the burial-transii	2		d										
g physical as the Medic	Ž.	IF FEMALE:						1.		T		-	
		23b. Was decedent pregnant	23	3c. If yes, outcome 1 \subseteq Live birth			Ectopic pregr	nancy		2	3d. Date of del		
e atten ed for u	5	in the past 12 months? 1 ☐ Yes 2 ☑ No		4 Pregnant a			Other (specify				Month	Day	Year
should be detached for use should be detached for use the should be detached for use the should be should		9 Unknown											
be de	2	Part II. Other significant cond	itions con	tributing to death t	out not res	ulting in the u	inderlying caus	se given in Part I.			e contribute to		
n sig	2								1 🗆	Yes 2	No 3 ☐ Pr	obably	4 🗌 Unkn
/n (V)									24a. Was		24b. Were au	topsy finc	lings avail
ate has page 2	5								perfo	ormed? 2 ☑ No	death?		
certificate irector, pa	D 2	25. Was case referred to media	al				· · · · · · · · · · · · · · · · · · ·	26. Place of De	ath (Check only o				
		examiner? 1 ☐ Yes 2 ➡ No	Н	ospital: 1 🖼 inpatie	ent 2 🗌	ER/Outpatien	t 3 🗆 DOA	Other: 4 Nursing h	fome 5 ☐ Resi	dence 6	Other (Spec	cifv)	
		27. Manner of Death		28a. Date of Inju	ry	28b. Time o	28c.	Injury at	28d. Describe				
rs afer death. al Director, Affer the led i by the funera Certification:		1 ☑ Natural 5 ☐ Pen- 2 ☐ Accident inve	ding stigation	(Month, Da	rear)	Injury		Work? 1 ☐ Yes 2 ☐ No					
oy the	2	3 Suicide 6 Cou	d not be rmined	28e. Place of inj	ury - At ho	me, farm, str	eet, factory, offi	ice	28f. Location (Number or Ru	ural Route	Number,
ore in		4 Homicide dete		building, et	u. (Specify)			City or Tov	vn, State)			
000			ing Phys	later. To the book	of my know	uladaa daath		and the second selection	e and due to the	causa(s)	and manner as	etated	
neral D		29a. Certifier 1 Certif	yilig Fitysi	ician: To the best of	inly know	vieuge, ueati	occurred at tr	ne time, date and plac	e, and due to the	Cause(s)	and manner as	stateu.	
Within 24 hours are to be a To the Funeral Director. Completely filled in by the Medical Certifical		29a. Certifier 1 ► Certifier (check only one)	al Examin	ier: On the basis o and manner st	f examinat	ion and/or in	estigation, in	my opinion, death occ	urred at the time	, date and	place, and due	e to the ca	ause(s)

d Number or Rural Route Number, and manner as stated. d place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) RE3 000 08 2010 600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year)

Amy

MD

32. Figistrar's Signature

30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print)

DEZERN

For

DHMH 17 Rev 1/2001

0.04049		B			2010 21817
0-04948 Pedro Antonio (Cana	Please Type or Print in Black Inde State of Maryland / Departr			ole.
		1- For State Certific	cate of Death		
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)		Reg. N 2. Date of Death	No. 3. Time of Death
Medical Exam		Pedro Antonio Canales		Month Da July 1, 2010	ay Year 2041 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		Prince George's Hospital	Cheverly		Prince George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		8. Date of Birth(N	MM/DD/YYYY) 9. Birthplace (State or Foreign E1 Salvador
Director		577-33-6498 1XM 2 F 31	Yrs. Months Days Hours Min	July 11,	1978 Country)
,		Usual Residence of Decedent			
w any		10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
land f sho	5	MD Prince George	Hyattsville		1 X Yes 2 No
with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
th the 23a o		2303 Fordham St.	20783		Il Salvador
5-0036 feed within 72 hours after death with the Maryland tygiene. other than "matural", or items 23a or 28a-fshe the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 	pecify Yes or No- Rican, etc.)	Race - American Indian, Black, White, etc.
er dez , or i	Ē	1 Yes 2 A No	1X Yes 2 No specify:Salv	adores	Specify: Hisp an ic
irs aft ural"	by	or Dates:	Decedent's Usual Occupation (Give kind of	The second second second	b. Kind of Business/Industry
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti		,
21215-0036 uid be filed within 72 ho marked Hygiene. marked other than "nı c event, the Medical Ex	Completed by	9th	Maintenance		Restaurant
15-003(iled within Hygiene. d other tha		17. Father's Name (First, Middle, Last)		(First, Middle, Maid	en Surname)
21 be fill mtal rrked vent,	æ	Antonio Gu e vara			za Velasquez
ID 21215 ! should be file and Mental H !? is marked o	70	(22001101)	9b. Mailing Address (Street and Number or I		
≥ 5 € 5 5			2303 Fordham St. Hyat		
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is man injury or other traumatit ev			of Disposition (Name of cemetery, atory or other place)	Date 20	c. Location - City or Town, State
altimo mit. Page partment portant:			ly Cemetery 07-	11-2010 E	1 Salvador
Baltimo permit. Pag Department Important:		21. Signature of Funeral Prvice Licensee	22. Name and Address of Facility W . H		
7	6	23a/Part I. Eyfter the disease, or complications that caused the death. On			gton, DC 20010 shock, or heart Approximate Interval
Physician /Medical		failure List only one cause on each line.	lot enter the mode of dying, such as cardiac c	respiratory arrest, s	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Acute Facterial Due to (or as a consequence of): T	Bronchoppeumonia Comp	licating	Torso
		Sequentially list conditions. b	rauma		
	ner	if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (C. Due to (or as a consequence of):			
uted Id ansit	_	d.			
ox 68760, auth certificate be execut attending physician and or use as the burial - tra	Physician/Medical	X UNPENDED X AMENDED #27 PST THE	g906 8-27-10 vt a-f,perME,G906,8/25/	2010 US	
760, icate be ex physician the burial	Mec	IF FEMALE: 23c. If yes, outcome of pregnance			23d. Date of delivery
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri	au/	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregna	ncy	Month Day Year
eath c eath c for us	sic	4 Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)		
D. B. tr the de by the ached f	Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I	23e. Did tobaco	co use contribute to the cause of death?
Records, P.O. The law requires, that the frame requires is that the page 2 should be detach	þ	Alcohol Use	, , , , , , , , , , , , , , , , , , , ,	1 Yes 2	No 3 Probably 4 ✔ Unknown
ords, w require s been si should b	ed			24a. Was an	24b. Were autopsy findings available
COT law r has b	Completed	·		autopsy performed	prior to completion of cause of death?
	ខ	OF 111			No 1 Yes 2 No
ician:	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/C	26,Place of Death (Check of Dutpatient 3 DOA Other Nursin	only one) g Home 5 Resi	
n of Vita ding Physician h. After this cer	읟	1 V Yes 2 No	Time of Injury 28c. Injury at Work?	28d. Describe how i	
C # _ ^ 4	<u>.</u>	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 X No		.,, 0555.,755
Division tal or Attendi rs after death at Director: /	icat	2 Accident Investigation Unknown Un	known farm, street, factory, office building, etc.	Unknown 28f. Location (Street	t and Number or Rural Route Number, City
Divis	ertification:	determined (Specify)	, , , , , , , , , , , , , , , , , , , ,	or Town, State)	
_ = - = - :	ပ	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, and	Unknown due to the cause(s)	and manner as stated
To the Hosp within 24 hos To the Fune completely fi	edical	one) 2 Medical Examiner: On the basis of examination and/or			
5 × 5 0	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
1 PEN		Chrose -	O.C.M.E.	Ju	ıly 2, 2010
L'		30. Name and address of person who completed cause of death (Item 23a)			
			Penn Street, Baltimore, MD 21201		
St	ate	31 Date filed (Month, Day, Year) 32. Registrar's Rignatur	del	_	
Regist		III 08 2010 Denus A. 190	W		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25^{Day} RICHARD WALLACE CARR Physician/ JÜNE 2010 7:03 AΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
MONTGOMERY BETHESDA NATIONAL INSTITUTES OF HEALTH Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-50-8748 1**X**□ M 2 □ F 06/14/1947 Washington, Director 63 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 72 hours after death with the Maryland Director Washington DC 1 kg Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20007 Funeral 4057 Highwood Court NW United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. ю Completed by 1 ☐ Never Married 2 🔀 Married 1 Yes : 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Ulidowed 4 Divorced Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 permit. Page 1 and 2 should be filed within ... Important: If item 27 is marked other than "any injury or other traumatic event, the Meionce. ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) <u>Real Estate</u> <u>Real Estate</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Josephine Ashby Oliver Taylor Carr Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4057 Highwood Ct. NW Washington, DC 20007 Marie Pinak Carr / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/2/2010 National Crematory Falls Church, VA 21. Signature of Funcial Service License 22. Name and Address of Facility Joseph Gawler's Sons Inc. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line.

ediate Cause (Final 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disea Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) WEEK Medical Due to (or as a consequence of): Examiner VERSUS DISEASE 2 MONTHS HOST Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed APLIASTX YEAR MEMIL physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 d. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Other (specify) Pregnant at time of death 2 🗌 No the hed 9 Unknown 9 Unknown by within 24 hours after death.

To the Funeral Director, After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 2 No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Nonpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) P L D0069053 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMV DADUED DITHT 10 CENTER DRIVE, BETHESDA, MD 20892 31. Date filed (Month, Day, Year) State **JUN 28** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 21819 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June BLANCHE DEGREE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S DOCTORS COMMUNITY HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 StF Months Days Hours Min. (Month, Day, Year) 10/18/1919 Columbus, NC Director 242-32-7376 Usual Residence of Decedent fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1103 Parkington Lane 20716 United Sates Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 ¬Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) House Wife Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should ce file ment f Health and M⊾ntal ည Willis Mc Alister Sallie Ballamy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin L. Minor / Daughter 1103 Parkington Lane Bowie, Maryland 20716 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 x Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 7/1/2010 Clinton, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facilit Pope Funeral Homes, P.A. A01085 1surg 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cogestive disease or condition Medical resulting in death) Examiner Respiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed en 9 cance, Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hyperten sum Completed 1 Yes 2 No 3 Probably 4 Onknown Diasetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate ☐ Yes 2 🗷 No 1 ☐ Yes 2 🗓 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 힏 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Prestitioners To the best of my knowledge, de 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/a7/10 and Men 165909 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Koud MD. 20706 8118 Lanham, Henry Good Luck 31. Date filed (Month, Day, Year

DHMH 17 Rev 7/2009

Registrar

JUN 3 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G905, 7/26/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Jameson Downing Vaughan June 11:57a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 9010 Briar Croft Ln. #405 Prince Georges Laure1 229538149396 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York **Funeral** 8 Date of Birth (Month, Day, 1 ፟ M 2 □ F Months Days Hours Min Director 75 Oct. Usual Residence of Decedent or 28a-f show 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director Maryland Prince Georges Laure1 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9010 Briar Croft Ln. #405 20708 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Employee Development Specialist Government permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Mea Elementary/Seconday (0-12) College (1-4 or 5+) 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Rogers Downing Myrtle James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Downing / Wife 9010 Briar Croft Ln. #405 Laurel, Md. 20708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Metropolitan 6/26/2010 4 Donation 5 Other (Specify) Alexandria, Va. of Funeral Service Licens Name and Address of Facility Pope. Alexander S. Pope. 5538 Mariboro Pike/ Forestville, Md. 21. Signatur 20747 0401051 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each mye. Interval Between Immediate Cause (Final ROSTATE CANCER. Onset and Death .Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of) burialnding physician ause as the burial-Physician/Medical Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy õ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day signed by t d be detach Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Tyes 2 No Other: 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A

completed filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of gertifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint) 7501 ENKA7 SURRATTS manan 31. Date filed (Month, Day, 32. Regist JUN 3 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MARY ALBERTA 2010 ELMO June 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3148 Gracefield Road. Silver Spring Prince George's #CL 104 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April I 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours Min Director 577-01-0731 102 1908 Pennsylvania Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's Silver Spring 1 🗌 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3148 Gracefield Road, Apt #CL-104 20904 U.S.A. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Fart: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chief Operator Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Povec Catherine Simko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine E. Fletcher/Daughter 9303 St. Andrews Place, College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Demoval from State permit. Page Department of Important: If any injury or Fort Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Signature of Funeral Service License 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or shock, or heart failure. List of applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between twone cause on each line Immediate Cause (Final Onset and Death Years Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or impury that initiated events Examine Due to (or as a consequence of) and burial-trar resulting in death) Last Due to (or as a consequence of) attending physician for use as the burlal Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 42 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Accident Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown page 2 should Contractures 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed certificate I 1 🗌 Yes 2 🗌 No Yes 2 🔀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Suicide 1 Yes 2 No Investigation he Funeral Director: pleted filled in by the 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours

24 within 2 To the

DHMH 17 Rev 7/2009

State

Registrar

29a. Certifier

(Check

only one) 29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year)

JUN 28 2010

1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Eugenio S. Machado, MD, 3110 Gracefield Road, Silver Spring, Maryland 20904

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Compression of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

June 25, 2010

29c. License number

D-24035

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Yea Jun<u>e</u> Charles 26 4:55 Gavai Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3715 Ferry Landing Road Calvert Dunkirk Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours 04-28-1934 Director 577-54-3065 76 Hungary Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Calvert Dunkirk 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3715 Ferry Landing Road 20754 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🏋 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir <u>م</u> 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced Completed Year or Dates white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 self employed iron worker welding, construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miklos Gavai Maria Kiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janis M. Gavai, spouse 3715 Ferry Landing Road, Dunkirk, MD 20754 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Highlands 06-29-2010 | Port Republic, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final nysician, disease or condition resulting in death) Metastatic Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (of as a consequence of) Exami Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the P.O. ed by tl been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed?
☐ Yes 2 🗓 No death? certificate 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🎇 Residence 6 ☐ Other (Specify) this After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 X Natural 5 Pending injury 1 Tes 2 🗌 No 2 Accident
3 Suicide Investigation Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide after City or Town, State) thin 24 hours af the Funeral Di mpleted filled in Medical 29a. Certifier 🛛 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 66881 June 28, 2010

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State Registrar Jonathan Kiev, M.D

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

., 2002 Medical Parkway, Ste. 660 Sajak Pav., Annapolis, MD 21401

IN 29 2010 Server S. Sauls

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 CHARLES AARON GRINBERG June 6:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New York Funeral (Month, 1 X M 2 □ F Months Davs Min Director 081-18-2943 85 1924 Oct. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9721 Hedin Drive 20903 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No WW Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 Widowed 4 Divorced II Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Photofinishing Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ervin Grinberg Bessie Schwartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miriam L. Grinberg/Spouse 9721 Hedin Drive, Silver Spring, Maryland 20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 06/28/ 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem.Gardens Olney, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, shock, or heart failure. Lis omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Fungemia Sequentially list conditions, Disi to (or as a consequence or): cause. Enter Underlying Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ cate has been signated by page 2 should by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 ☐ Yes 2 ☐ No Yes 2 X No upleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: 유 1 X Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural injury 5 Pending work? 1 Yes 2 No s after death. ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Registrar
DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JUN 28

D0052586

1500 Forest Glen Road, Silver Spring,

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d Layanti

MD,

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jayanti Lalbhai Patel,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21824 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 A^{M} Lacinia June 9:56 Greene Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) 6. Social Security Number 415-16-6676 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗓 Min. 6-28-1918 Hours Director Johnson City. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified ∎t 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Mt. Rainier 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3331 Buchanan Street 20712 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or 1 Never Married 2 Married ð Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be John W. Price Flora B. Sanders other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mary R. Jones (sister) 3331 Buchanan Street Mt. Rainier, MD 20712 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 X Removal from State Kensico Cemetery July 3, 2010 4 Donation 5 Other (Specify) Valhalla, NY any inj once, Signature of Funer | Servi | See 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ģ Month Year Day been signed by the a should be detached t 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' 1 Yes 2 No Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) မ 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 I DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred After 1 X Natural (Month, Day, Year) 5 Pending s after death.

I Director: Af 1 Yes 2 No Accident Investigation 6 ☐ Could not be 3 Suicide 4 Homicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner 1. the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of po

JUN 3 0 2010

73257AHOMONES PARKWAY GREGGEGELI MARILAND 2072

ted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 21825 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lewis Colbert Hall June 7:35 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1320 Flag Harbor Blvd. St. Leonard Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09–15–1937 **Funeral** 9. Birthplace (State or Foreign Months 1 💢 M 2 🗆 F Hours 217-34-1769 72 Director Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD Calvert St. Leonard 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1320 Flag Harbor Blvd. 20685 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 1963 Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Warehouse Supervisor Boeing Aircraft Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Winslow Hall Georgetta J. Polley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ada E. Hall - Wife 1320 Flag Harbor Blvd., St. Leonard, Maryland 20685 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 7/1/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 0. Box 600, Lusby, Maryland 20657 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition 018 NO Medical resulting in death) Examiner SINCE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Month 2 No 1 ☐ Yes 2 L 9 ☐ Unknown the detached cate has been signed by page 2 should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 🔀 Unknown 013earl 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Bear perform certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No ☐ Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 1. Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) June 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mehesh P. Shah, MD 130 Hospital Road, Suite 300, Prince Frederick, Maryland 20678

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

32. Registra s Signature

JUN 28 2010

Curtis Hamilton		St	ate of Marylan	d / Depa	artment of	Health and			_	21826	
		1- For State Registrar		Cei	rtificate of	Death			eg. No.		
Physici Medical Exami		1. Decedent's Name (First, Middl Curtis Hamilt						2. Date of Dead Month June 28, 2	Day Year	3. Time of Death 1040 hrs	
		4a. Facility Name (if not institutio	n, give street and numb	per)		4b. City, Town, or			4c. County of Deat	h	
1		508 Juniata Street Ap				Havre de G			Harford		
Funeral Director		5. Social Security Number		Age (In yrs. la		If Under 1 Year Months Days			th(MM/DD/YYYY) 9. Bii Forei	gn	
Bileotor		219-56-6371 Usual Residence of Decedent	1 XM 2 F		58 Yrs			April	4, 1952 C	ountry) KY	
any		10a. State 10b. County		10c. City,	Town or Locat	ion				10d. Inside City Limits	
Aaryland 28a-f show 1 at once.	'n	MD Harf	ord	Havi	re de G	race				1 X Yes 2 No	
Maryl 28a-f	Director	10e. Street and Number				10f. Zip Code		11	0g. Citizen of What Cou	ntry?	
death with the Maryland or items 23a or 28a-f sho must be notified at once.		508 Juniata S				21078			USA	Disal	
ath wi	Funeral	11. Marital Status 1 Never Married 2 Ma		es?		s Decedent of His es, specify Cuban			White, etc.	ican Indian, Black,	
fter de l'', or		3 Widowed 4 X Div	1 Yes	2 X No	1	Yes 2 X No	specify:		Specify: Wh	ite	
ours a	ed by	15. Decedent's Education (Spec	Lor Dates: cify only highest grade of	completed)		t's Usual Occupat ost of working life.			16b. Kind of Business/	Industry	
36 n 72 h nan "n ical E	plete	Elementary/Secondary (0-12)	College (1-4	or 5+)	_			an ed)			
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be exec	Physician/Medical	UNPENDED	AMENDED								
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x 68 h certif	iciar	past 12 months?	I LIVE DILLI	at time of de		tal death 3 [ner <i>(Specify)</i>	Ectopic pregr	nancy	Month	Day Year	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bundered by the funeral director, page 2 should be detached for use as the bundered by the funeral director, page 2 should be detached for use as the bundered by the funeral director, page 2 should be detached for use as the bundered by the funeral director, page 2 should be detached for use as the bundered by the funeral director.	edical	(Ondon only	niner:On the basis of e	xamination ar							
To To	Me	29b. Signature and little of certifie	and manner state	1///	380	29c. License	number		29d. Date signed (Mo	nth, Day, Year)	
		(tell /s	the //e,	el	10.	O.C.1	M.E.		June 29, 2010		
5		30. Name and address of person					-14:	204004	·		
	nte	Victor Weedn MD JD 31. Date filed (Month, Day, Year)	Assistant Medic			enn Street, B	aitimore, ME	21201			
St Regist	ate rar	JUN 3 0 20		u ai s Gigiratti	park	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Day 9:12 AM W. June 22 Hopkens 5010 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Mitchellville Villa Rosa Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. | 1922 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🕇 F North Carolina 88 244-24-2024 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No Upper Marlboro Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20774 United States 42 Laughton Street 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Specify: African 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖺 No Specify 3 XWidowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Government Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ada Louise Green Benjamin Mclendon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20774 42 Laughton Street Upper Marlboro, Maryland Cherryl H. White/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony 20c. Location - City or Town, State Date 20a. Method of Disposition 28, 1 Burial 2 □ Cremation 3 □ Removal from State Landover, Maryland 4 □ Donation 5 □ Other (Specify) 2010 Memorial 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sign 4001 Benning Road NE Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Right frontoparietal intracranial hemorrhage Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Cerebrouseu autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident

Physician /Medical Examiner Examiner The law requires that the death certificate be executed and

permit. Pages Department of Important: If it any injury or c

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

/Medical

Directo

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Completed

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2

use as the burial-tra attending physician signed by the a should page 2 this certificate director. funeral

or Vital Records, P.O. Box 68760,

Physician/Medical Completed by Medical Certification: To Be

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and titl

within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

or Attending Physician:

Division

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smith Aue

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Baltinene, Mdz1200

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) JUN 3 0 2010

6 ☐ Could not be determined

32. Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D008333 10-04754 Jean Innocent Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

an innocent		For State	Certificate			100000000000000000000000000000000000000	Reg.	No. 201	0 21828
Physicia	n/	egistrar . Decedent's Name (First, Middle,Last)				2		ay Year	3. Time of Death 1747 hrs
edical Examir		Jean Innocent JAMES INNOCENT		I dh. City. To	wo or L	ocation of Death	June 24, 20	4c, County of Do	
		Fort Washington Hospital Center		Fort W				Prince Geo	
Europal	4		(In yrs. last birthday)) If Under	1 Year	If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9.	Birthplace (State or
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212' Jid be Menta marke	To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address	(Street	and Number or Re	ural Route Numb	er, City or Town, S	State, Zip Code)
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re, ME s 1 and 2 s f Health a If item 27		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from Sta	20b. Place of Di	sposition (Nam or other place)	e of cerr	netery,	Date	20c. Location - Cit	ty or Town, State
MOT Pages ent of int: I		4 Donation 5 Other Specify:	Maryla:	nd Vete	rans	7/1	/2010_	Cheltenh.	am, Maryland
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati	16	21. Signature of Funeral Service Line see		22. Name and	Address	of Facility Pope	e Funera	1 Homes,	P.A.
		23a. P. F. Enter the diseas, or complication, that caused	the death. Do not en	5538 Ma	rlbo	oro Pike such as cardiac or	Forestv respiratory arres	ille, Ma st, shock, or heart	ryland 20747 Approximate Interval
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687 certific nding se as t	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant a	t time of death 5	Fetal death Other (Spec	3 (cifv)	Ectopic pregna	ricy	WOTH	Day 10s.
Box 687 e death certific the attending p ed for use as th	Physician/	1 Yes 2 No 9 Unknown 9 Unknown							
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tal Rec cian: The certificate	٦	25. Was case referred to medical	ient 2 🗸 ER/Outp		26.Place	of Death (Check Other Nursin		Residence 6	Other:
Division of Vital Records, P.O rat or Attending Physician: The law requires that the after death. In a librector. After this certificate has been signed by the finest of the forest of the state.	F	1 V Yes 2 No 28a Date of In	iury 28b. Tin			ry at Work?	28d. Describe h	ow injury occurred	
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risic r Atte	fical	2 Accident Investigation Jun 24, 201 3 Suicide 6 Could not be	Injury - At home, farm		, office t	ouilding, etc.	28f. Location (S or Town, St		or Rural Route Number, City
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Division of Vital Protein of Vital Proteins within 24 hours after death. To the Functial Director After this certification of the function of the control of			ny knowledge, death amination and/or inv	occurred at the estigation, in m	e time, d y opinior	ate and place, and n, death occurred a	due to the cause at the time, date a	e(s) and manner a and place, and due	s stated e to the cause(s)
To th within To th	Modical	one) 2 Medical Examiner: On the basis of exa	1.			se number			(Month, Day, Year)
	*	I and I			O.C.	M.E.		June 25, 201	10
		30. Name and address person who completed cause of	death (Item 23a)						
R 5		Jack Titus MD. Deputy Chief Medical	Examiner 11		et, Ba	Itimore, MD 2	1201		
	Sta	e 31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	1					
Reg	Ыľ	111N 9 0 2010 Server	· /7						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mine 23, 2010 William Edward Johnson, Sr. 4:50 p м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Hospice House Prince Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe . Age (In yrs. last birthday) Funeral 1 X M 2 □ F (Month, Day, Year) May 4, 1937 Country)
MD Director 73 214-36-2714 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 - Yes 2 X No MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 660 Santa Fe Trail 20657 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Completed 3 - Widowed 4 Divorced Black Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Equipment Operator** Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Hester Walter Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHNSON, 660 Santa Fe Trail, Lusby, MD 20657 Corrita Johnson-Myers - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Brooks UMC Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State June 30, 2010 St. Leonard, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final CARCINOMA Pnysician/ PROSTATE disease or condition resulting in death) سيعي Medical Due to (or as a consequence of): Examiner Sequentially list conditions. pue to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Exami the Hospital or Attending Physician: The law requires that the death certificate be executed with 24 hours after death. The the state death. The Funeral Director. After this certificate has been signed by the attending physician and mileted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PARKINSONISM Division of Vital Records, 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 10 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 105pice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24/10 D3696 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUSBY SCARIA MATHEM mo PO BOX 1789

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Yea.

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 21830 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25^{Day} 2010 LILLIE MAE JOYNER June 8:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Prince George's Hospital Cheverly Prince George's Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🕱 F Months Days Hours Min (Month, Day, Yea North Carolina 577 -40 -1261 Director May Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director District of Columbia Washington 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funera 20019 Hayes St., N.E. USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 0 1 Never Married 2 Married Completed by filed within 72 hours after 1 ☐ Yes 2 🖾 No Specify: Black "natural", Specify: 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than , College (1-4 or 5+) Elementary/Seconday (0-12) should be filed within and Mental Hygiene. 9 Domestic Private Page 1 and 2 should be filed with ment of Health and Mental Hygie tant: If item 27 is marked other. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Jefferies Herbert Brown Clara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Clark, Goddaughter Nash Pl., S.E. #101 Washington, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 07/02/2010 Lincoln Memorial Suitland, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice is 22. Name and Address of Facility Jordan Funeral Service, Inc. 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Septic Shock Medical resulting in death) Due to (or as a conseq Bacteremia (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Acute Renal Failure as the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Acute Ventilator Dependent Respiratory Failure IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No 9 Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiac Arrest X 1 Tes 2 No 3 Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 🔀 No ပ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 🖪 Natural work? 5 Pending injury 2 Accident
3 Suicide Investigation s after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined City or Town, State) Hospital within 24 hours: To the Funeral Medical 29a. Certifier 1 🔀 Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

State

filed (Month, Day, Year) JUN 3 0 2010 Registrar

Cumberbatch, MD

30. Napre and address of person who completed cause of death (Jem 23a) (Type, Print)

will

3001 Hospital Drive.

Cheverly, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2010

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUNE 2010 **ETTOREE** JOHNSON 12:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Gaithersburg Montgomery 107 Spring Street If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🔽 F 98 250-26-3622 Director South Carolina 1911 October Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or items 23a or 28a-f ehow 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Evanding must be notified at 1 X Yes 2 □ No Director Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 IISA 107 Spring Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2K If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2K No Baltimore, Maryland 21215-0036 1 ∐Yes 2. No Specify ģ Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 4th College (1-4or 5+) Homemaker Private 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event one. 17. Father's Name (First, Middle, Last) Be Lola Clyde John Brown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Spring Street, Gaithersburg, Maryland 20877 Bettie McLean - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park July 3, 2010 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Freeza Socvice Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOMYOPATHY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No for Month Day Vear 5 Other (specify) 9 Unknown 9 Unknown signed the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation nin 24 hours after death the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Hospital 29a. Certifier 1🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cert/ MD June 29, 2010 D0063196 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Matthew McAndrew, M.D., 110 Irving Street, NW, Washington, DC 20010 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 3 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Marylan		irtment of H <i>tificate of D</i>			giene 2010	21832
			Decedent's Name (First, Middle, Las	t)				2. Date of Deat	th	3. Time of Death
	Physicia Medic		George Augustus					June	25, 2010	1620 P⋅ M
	Examin	er	4a. Facility Name (if not institution, give			4b. City, Town, or			4c. County of Dea	
4 سيد			Holy Cross Hos 5. Social Security Number 6. Se		st birthday)	S11ve	Spring If Under 24 Hrs.	8. Date of Birth	Montgom	ery irthplace (State or Foreign
	Funeral Director			⊠ м 2□ F 7 6	Yrs.	Months Days	Hours Min.	08/09/	1933 Was	n.,D.C.
	t ow	L	Usual Residence of Decedent 10a. State 10b. County	100 Cib	, Town or Loc	eation				10d. Inside City Limits
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	or 28 e noti	Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	s 23a nust b	Funeral Director	4937 Lee St.	,N.E.		2001	19		U.S.A	•
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		
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Baltimore, Maryland	d 2 shoul alth and I n 27 is ma er trauma		19a. Informant's Name/Relationship (T) Phyllis I. Janife			g Address (Street a Lee St., l			City or Town, State, 2	
ore	e 1 an t of He If iten or oth		20a. Method of Disposition 1X Burial 2 Cremation 3 C		lace of Dispos emetery, crem	sition (Name of natory or other place	e)	Date	20c. Location - City of	or Town, State
ţ.	t. Pag tment rtant: njury o		4 Donation 5 Other (Specif	y) Har		lem. Park		02/10	Landover, M	aryland
Bal	permit Depar Impor any in	, ,	21. Signature of Funeral Service Licens	Sall	4	925 Burre	oughs Ave	NE	Sons Co.,I Washington	nc. , D. C. 20019
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, interval to the shock, or heart failure.									Approximate Interval Between Onset and Death
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200	icate t physis the	ledical		d						
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to the Funeral Director. After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c	ldeath 3 🖵	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	delivery Day Year
P.0	s that t gned b be deta	by	Part II. Other significant conditions	-	ulting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 🗌 Unknown
rds	equire een si nould l	eted	Bladder Cance	er						
Reco	The law rate has b	Completed	Septic Shock					24a. Was a autop perfor 1 Yes	sy prior to med? death?	autopsy findings available o completion of cause of ? /es 2 No
ta	ician; certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe	ace of Death (Chec			
<u>ک</u> (Phys rrthis eral dii	e: 10	1 Yes 2 No 27. Manner of Death	1 Impatient 2 2 28a. Date of injury	28b. Time of	it 3 □ DOA 2 28c. Injury	4 LI Nursing Ho		ence 6 Other (Spe ow injury occurred	ecify)
uc	inding ath. r: Afte	icat	1 Natural 5 Pending 2 Accident Investigation		injury	M 1 □	? Yes 2 🗆 No			
Divisi	al or Atte s after de il Directo ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
	ne Hospit n 24 hour ne Funera pleted fille	Medical	(Check 2 Medical Exam	sician: To the best of my knowl iner: On the basis of examination se Practioner: To the best of my	n and/or invest	igation, in my opinio	n, death occurred a	t the time, date ar	nd place, and due to the	e cause(s) and manner stated.
	Vithi To th		29b. Signature and title of certifier	11111	S	29c. License			29d. Date signed (Mor	
)			- Willer		D006	133/		June 25,20	10
	5		30. Name and address of person who candace L. Wilso	on, M.D. 1500 Fo	rest G		Silver S	Spring,M	aryland 2	20910
	Sta Registr		31. Date filed (Month, Day, Year) JUN 3 0 2010	32. Registrar's Signat	ture					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month June 20 = 20 M Thomas Lee Kellam Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SALISBUN **FENINSULA** HIGMICO Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1**X** M 2 □ F Months Hours Min **Director** 226-58-8549 66 08/02/1943 Usual Residence of Decedent 28a-f show 10a. State 10b. County be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Temperanceville 1 🗆 Yes 2 🔀 No VΔ Accomack 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral "natural", or items 23 23442 U.S.A 11523 Charity Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Specify Black Completed Year or Dates 27 is marked other than "natu traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. J&J Band Aid Technician 12th Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ should be Frederick Douglas Bertha Taylor oft. Page 1 and 2 shou...

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of 15 fam? 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth V. Kellam/wife Charity Lane/Temperanceville/23442 item 2 11523 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 07/03/10 |Temperanceville/VA <u>Jerusalem Baptist :</u> . Signature uneral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. <u>Bennie Smith Funeral</u> Home/Salisbury,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ allure hespiratory disease or condition resulting in death) Medical Examine Cancer astatic Non-Small Cell Lung Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant 9 Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 No 2 X N Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 은

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Other: 4 \(\subseteq \text{Nursing Home} \(5 \subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 2 XNo 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

29a. Certifier (Check

Certificate:

Medical

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

29b. Signature d title of certifier ned (Menth, Day, Year) D66198

s of person who completed cause of death (Item 23a) (Type, Print)

JUN 25

CARROLL St. SAlisbury Md 2180 mD JUSTINIAN NaAizA 100 €.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Maryl		artment of rtificate of		d Mental H	ygiene Reg. N 20	10	21834
	Physici	an	1. Decedent's Name (First, Middle,	ast)					2. Date of D	eath Day	Year	3. Time of Death
	/Media	cal	Mary A. Long 4a. Facility Name (If not institution, g	ive etreet and a	(mbor)		4h City Town	or Location of De	June	25,0	y of Death	1410 M
1	Examir	ner	Salisbury Rehabil			na Ctr.	4b. City, fown,	lisbun	eath .	Wir	20m i	c 3
	Funeral			Sex 1 ☐ M 2 □ F		yrs last birthday)	If Under 1 Year Months Days	If Under 24 F		irth Day, Year)	9. Birth	
	Director		219-62-9292 Usual Residence of Decedent	10 W 2 X	57	Yrs.			6-14-	1953	MD	
	ryland how		10a. State 10b. County		10c	. City, Town or Lo	cation				1	Od. Inside City Limits
	Ba-f s	Director	MD Wicomi	co	S	alisbu:						1 X es 2 No
	with the		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	death ms 23	Funeral	509 Chelsea C	12. Was Dec	edent Ever i	in U.S. 13.	21804 Was Decedent of		(Specify Yes or Nerto Rican, etc.)	USA lo- 14. Ra	ice - Ameri	
36	or ite		1 Never Married 2 Married	If Yes, G	2 X □ No ive		it Yes, specity Cul 1 □Yes 2X(No		erto Rican, etc.)		ack, White, by: Blac	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Madical Experience must be nutified at	ed by	3X Widowed 4 ☐ Divorced 15. Decedent's	Year or I	Dates:		dent's Usual Occu			16b. Kind of E		
255	hin 72 e. an "na	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (i (Give	kind of work done DO NOT use retire	during most of v	vorking	100. Kind of E	J aoine35/11	dustry
212	filed wit Hygien other the		12			Cas	hier	1:::				t Store
and and	d be fill ental H ced otl	Be	17. Father's Name (First, Middle, La Freeman R. Jo	•					lame (First, Middl		me)	
ary C	should and Men s marke umatic	၉	19a. Informant's Name/Relationship		rothe	19b. Mailii	ng Address (Stree		E. Wri		n, State, Zip	Code)
S.	and 2 lealth a m 27 ls		Alexander Lee		s/	505	Lobloll	y Lane	, Salis	bury, 1	MD 2	1801
Mary Lond Baltimore, Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Eventhe must be nettred at once.		20a. Method of Disposition Burial 2 Cremation 3		State	cemetery, crei	natory or other pla	ace)			,	,
ıtin	nit. Pa artme ortant injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	- A	E	lzey U			3-2010	Jeste		
B	Per Dep any		Quarell	For	_	I .	ennie S uneral		917 W. Salisbu			
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	nplications that	caused the c						2.0	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. 11/10	1 co	74/	euro !	xiles				Onset and Death
7	/Medical Examiner		rosaning in acathy	Due to	(or as a con	sequence of):						
	D #=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	(or as a con	sequence of):						
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	(or ac a con	sequence of):						
8760,	e be e sician s buria	dical E		Due to	(or as a con	sequence or,						
.89	rtificate ng phys as the	Nedio	15 50111 5	u								
Вох	leath certific attending p	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		birth 2 🗆 I	Fetal déath 3 [∃Ectopic pregnan	су			ate of deliv	ery Day Year
o.	the de y the a ched fi	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Preg 9 □ Unki	nant at time nown	of death 5	Other (specify)			191		Day Ical
Division of Vital Records, P.O.	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions	contributing to d	eath but not	resulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use cor	ntribute to t	he cause of death?
ord	equire een siç ould b	ted t							_ 1□	Yes 2⊡+No	3 ☐ Prol	bably 4 ☐ Unknown
Jec	e law has b je 2 sh	Completed							– 24a. Wa	s an 24b.	Were auto prior to co death?	ppsy findings available impletion of cause of
Ta I	sician: The law certificate has t irector, page 2 sl	CO .	25. Was case referred to medical					00 Plant of F		2 1 No	1 ☐ Yes	2 🗆 No
f ×	nysicia nis cer direct	P P	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	2 🔲 ER/Outpatier	nt 3 DOA Ot		g Home 5 Res		ther (Speci	fv)
0 0	nding Physician: th. : After this certifica : funeral director, p	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		of Injury th, Day, Yea	r) 28b. Time of Injury	Wo	ıry at rk?		how injury occu		
isio	Attend death ctor: /	ficati	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	ha	of Injury - 4	At home, farm, str]Yes 2 □No	28f Location	(Street and Num	her or Rur	al Route Number,
Ö	al or / s after il Dire ed in b	Certification:	4 ☐ Homicide determine	build	ing, etc. (Sp	At home, farm, str pecify)	, 120121), 011100		City or To	wn, State)	ber er rian	arribate riamber,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as t	ledical (29a. Certifier 1 ☐ Certifying I (Check only one) 1 ☐ Medical Ex	miner: On the t	best of my basis of exar iner stated.	knowledge, deat nination and/or in	n occurred at the vestigation, in my	time, date and pl opinion, death o	ace, and due to the	e cause(s) and n	nanner as : , and due t	stated. o the cause(s)
_	Vithir Comp	Me	29b. Signature and title of certifler	111	0		29c. Licen	se number	0	29d. Date sign	ed (Month,	Day, Year)
	B.			10/10	u		00	1999	7'	2/2	8/1	8.
	gu		30. Name and address of person wh	completed cau	se of death ((Item 23a) (Type,	Print)	AND	Salist	Sure 1	n >	21804
	Sta		31. Date filed (Month, Day, Year)	32.	égistrar's Si	ignature	OIVIC	, , , , ,	<u>uqıst</u>	21911	11.1)	arou T
	Registra	ar	JUN 29	UIU A	nun	A. A	are					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}010 Physician/ James Carroll June 24, 8:30 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Montgomery Hospice-Casey House Derwood 8. Date of Birth (Month, Day, Year) May 5, 1930 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 242-44-1723 1 🔀 M 2 🗆 F 80 Hours North Carolin **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Prince George Maryland Hyattsville 1 ☐ Yes 2 K No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2415 Fordham Place 20783 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1x Yes 2 No If Yes, Give 1 1 ☐ Yes 2xx No Specify: 1952-54 3 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Brick Mason Be 17. Father's Name (First, Middle, Last) snould be file th and Mental H. 18. Mother's Name (First, Middle, Maiden Sumame) Robert Bradley Love Lillie Margaret Clayton other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2415 Fordham Place, Hyattsville, MD 20783 permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Lola Love/Wife 20a. Method of Disposition Date 29 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20c. Location - City or Town, State 1 🗆 Burial 2 🍱 Cremation 3 🗆 Removal from State June 2 2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, Michard & Helen MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any linearing to immediate Examiner Due to jor as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 2 No ed by the a Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signature Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 Yes 2 No 2 XN this certific ral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospice 2 😾 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident Investigation 6 Could not be Suicide ☐ Suiciae ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) June 24, 2010 8115108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Diane Ruckert, CRNP

31. Date filed (Month, Day, Year)

2. Registrar's Signature

1355 Piccard Drive, #100, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 21836 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 24, J. 2010 9: 5 p Lemaire Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fairland Adventist Nursing & Rehab. Center Silver Spring Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year, 1934) 1 □ M 2 🔀 F Months Days Hours Min. 066-34-1183 75 fautt Director July 8, Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Montgomery 1 Yes 2X No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8509 Cloverfield Road 20910 Haiti Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc.
Multi-Racial δ 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 HNo Specify: If Yes, Give "natural" Specify 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bank Supervisor Banking is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Mental ပ Ferdinand Jean Jacques Lea Cameau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health a
Important: If item 27 is
any injury or other trau
once, Jacques Lemaire/Husband 8509 Cloverfield Road, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) July 1, 2010 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Keehard & Getes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 3 months Physician/ End-Stage Renal Disease Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2X No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hypertension, Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Tunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 🗌 No 1 🗌 Yes 2 😿 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🗵 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) ပ 1 🗌 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 IDOA . Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation s after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical 29a, Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the P within 2 To the F only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 29b. Signature 29d. Date signed (Month. Day, Year) D28656 2010 June 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Ravi Passi, MD

JUN

31. Date filed (Month, Day, Year)

Rockville, MD 20850

15245 Shady Grove Road, #130,

37. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21837 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ John C. McGuffin 24 6:23. P.M June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6787 Keller Lime Plant Road Buckeystown Frederick Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 213-40-4397 1 🔀 M 2 🗆 F Months Days Hours South Carolina Director 69 Dec. Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Frederick 1 Tyes X No. Buckeystown 10e. Street and Number 10f. Zip Code ò 109. Citizen of What Country? USA 23a Funeral 6787 Keller Lime Plant Road 21717 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò δ 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic seconds. Elementary/Seconday (0-12) College (1-4 or 5+) Comptroller US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည McGuffin Eloise Bumbarger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janis McGuffin/Wife 6787 Keller Lime Plant Rd., Buckeystown, MD 21717 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6/26/2010 Stauffer Crematory Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, 1621 opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ neumonia disease or condition resulting in death) Medical Examiner Cell Lyuphoma Large Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir ng physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardio myopathy 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe Yes 2 D or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify, 2 1 No 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending hours after death.

neral Director: After filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)
June 25, 2010

Registrar DHMH 17 Rev 7/2009

State

Kanan Hudhud, MD 31. Date filed (Month, Day, Y

12+1

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Ste 200 Frederick, MD 21702
Kanan Hudhud, MD 46B Thomas Johnson Drive, Ste 200 Frederick, MD 21702

141866-

15t |

I or Attending Physician: after death.
Director: After this certifica

To the Hospital of within 24 hours a To the Funeral D

The law requires that the death certificate be executed

Box 68760

P.O.

of Vital

Division

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

n and Mental F

State Registrar

31. Date filed (Month, Day, Year)

Marles

29b. Signature and title of certifie

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennett M.D.

Charles W. Bennett, MD 11845 H. G. Trueman Road, Lusby, Maryland 20657 D. Sarke

29c. License number

25156

29d. Date signed (Month, Day, Year)

June 26, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 5827 Crande11 Road Lothian If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X Months Hours Min 01-14-1930 Maryland **Director** 579-36-0310 80 Usual Residence of Decedent 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertal Hygiene. It liem 27 is marked other than "natural", or items 23a or 28a-f shoo other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎇 No Lothian Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5827 Crandell Road 20711 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify: white Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Wachter Josephine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health at: 5827 Crandell Road, Lothian, MD William C. Maske, spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗀 Donation 5 🗆 Other (Specify) any injury or Important: St. James Parish 07-02-2010 | Lothian, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** OF CECUM FORATION Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed' death? certificate 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗀 💦 o ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Tyes 2 🗆 No Investigation Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Practioner To the best of my knowledge, de 29b. Signatus and title of certific 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

20

State

39. Name and address of person

31. Date filed (Month, Day, Year)

diku

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 | 8 4 0 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Roslvn Mizell McLeod June 23 9:30 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Adelphi Prince George's Hillhaven Nursing Center, Inc. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Min. Sept. 9, 1920 Coupto) L**o**uisiana 439-16-7492 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 😾 No Garrett Park Maryland Mon toomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20896 P.O. Box 495 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give ₩₩/TT ı "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Year or Dates. WWII White 3 N Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry within Hygiene. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic evectors. ည Velma Adelia Erwin Claude Lannese Mizell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 495, Garrett Park, MD 20896 19a. Informant's Name/Relationship (Type, Print) Stanley McLeod/Son 20b. Place of Disposition (Name of Cemetery, crematory or other place)

Gate of Heaven Cemetery 20a. Method of Disposition 20c. Location - City or Town, State June 28 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specific 2010 Silver Spring, Maryland 21. Signature of Funeral Se 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 icelicense 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Cardiorespiratory Arrest Medical resulting in death) Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Atherosclerotic Cardiovascular Disease the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Diabetes Mellitus, Type II IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Year Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ law requires Completed Congestive Heart Failure, Hypertension, Atrial Fibrillation 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Hospital or Attending Physician: The least hours after death.
Funeral Director: After this certificate h 2 🗆 No ☐ Yes 2 🔀 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 **X**No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending after death. 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of centil 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Oney Zoniga, MD

31. Date filed (Month, Day, Year)

21215-0036

Baltimore, Maryland

68760

Box (

P.O.

Records,

Division of Vital

4701 Randolph Road, #216, Rockville, MD 20852

person who completed cause of death (Item 23a) (Type, Print)

D47867

June 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ALBERT P. MCGEE PJune 24, 2010 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6935 Decatur Place Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Days Hours Min 578-54-1344 69 April 4, 1941 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits MD Director Prince George's Hyattsville 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6935 Decatur Place 20784 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 ∐Yes 2 **∑** If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2X No Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Federal Government Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sammy McGee Eunice B. Lumpkins ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Wright - Sister 6935 Decatur Place, Hyattsville, Maryland 20784 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery July 3, 2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIOPULMONARY ARREST disease or condition resulting in death) Due to (or as a consequence of) BLADDER CANCER Sequentially list conditions Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEIZURES 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERCHOLESTEROLEMIA 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 X No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1∐Yes 2⊠ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, n 24 hours after death.

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Funeral

Director

28a-f show

ir than "natural", or items 23a or 28a-f short to Medical Evantiner must be notified at

2 should be filed within 72 hours after and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event

Physician

/Medical

Examiner

and burial-tran

attending physician for use as the buria

signed by the

cate has t page 2 s

certificate

After

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

the SB

Baltimore, Maryland 21215-0036

death with the Maryland

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Wilson, M.D., 106 Irving Street, Suite 315 South, NW, Washington, DC 20010 32. Registra's Signature

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MD 11903 / DC

29d. Date signed (Month, Day, Year)

June 29, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year Physician CHARITY MCCRAE MERRITT 5:20 a 25 JUNE 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES BRADFORD OAKS NURSING & REHAB CLINTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 3/23/1926 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗗 F WILMINGTON, NC 242-32-5399 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, I'v Wolcal Evan Increases be rediffed at Maryes 2 No Director DC WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20001 UNITED STATES 1921 2nd ST. NW death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Everandone. Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: BLACK 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 yrs SUPERVISOR DC EMPLOYMENT SERVICE yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be J.D. MCCRAE RERTHA BATTS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1921 2nd ST. NW WASHINGTON, DC 20001 CARLA MARIA MERRITT / daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify) 7/ 1/ 2010 CHELTENHAM, MARYLAND CHELTENHAM VETERANS 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME, LLC 21. Summure of Juneral Service L 3005 12th ST. NE WASHINGTON, DC 20017 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) A Seare Anteriosc **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a revision securities of the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗫 o Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1 ☐ Yes 2 Dolo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Civinpilm Rond 11701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 3 0 2010

DHMH 17 Rev 1/2001

Registrar

Division or Vital Records, P.O. Box 68760,	1	Baltimore, Maryland 21215-0036
pital or Attending Physician: The law requires that the death certificate be executed burs after death.	Phy: /Mc	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit	sicia edica	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physic /Med Exam

Funera Directo

	- FOI	Department of Health and N Certificate of Death	Mental Hygien 2010 21843								
ian	Decedent's Name (First, Middle, Last)	1	2. Date of Death Month Day Year 3. Time of Death								
cal	Mattie Olivia Mil. 4a. Facility Name (If not institution, give street and number)	Lard 4b. City, Town, or Location of Death	June 19, 2010 03:07 M								
ner	Fort Washington Hospital	Fort Washing	ton Prince George's								
	5. Social Security Number 6. Sex 1 M 2 SF 7. Age (In yrs. last birth	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 11, 1923 9. Birthplace (State or Foreign Country) Maryland								
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits								
Į.	Maryland Prince George's	Temple	4777								
irect	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?								
a D	3200 Curtis Drive # 209	20748	United States								
by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 1 No Specify:	ecify Yes or No- Plican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black								
Be Completed by		Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business/Industry								
omp	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired) Elevator Operat	cor Government								
Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname) 011ie Thomas								
P	Augustus Offer		ral Route Number, City or Town, State, Zip Code)								
	(· // · · · · · /)11 Cooper Drive For									
	20a. Method of Disposition 20b. Place of cemeter 1 Burial 2 □ Cremation 3 □ Removal from State	Date 28, 20c. Location - City or Town, State									
	4 □ Donation 5 □ Other (Specify) Memor	Landover, Maryland ewart Funeral Home, Inc.									
	4001 Benning Road NE Washington, DC										
	23a. Part Inter the disease, or complications that caused the leath. Do r shock, or heart failure. List only one cause on each line.		or respiratory arrest, Approximate Interval Between Onset and Death								
	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the conse										
L	Sequentially list conditions b. Atheroscu	vascular Discase.									
Examiner	any, leading to immediate cause. Enter Underlying Cause (Cisease or injury that initiated events										
Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of	to (or as a consequence of):									
dical	d										
Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	23d. Date of delivery Month Day Year									
Phys	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in	23e. Did tobacco use contribute to the cause of death?									
ed by	Palmonary Fibrosis	1 Yes 2 No 3 Probably 4 Unknown									
Complet	24a. Was an autopsy prior performed? de la la la la la la la la la la la la la										
Be	25. Was case referred to medical examiner? Hospital:	Other:	th (Check only one)								
n: To	27. Manner of Death 28a. Date of Injury 28b. T	Time of 28c. Injury at	ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred								
catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No									
ertifi	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, fa building, etc. (Specify)	ırm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Medical Certification: To	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.		e, and due to the cause(s) and manner as stated. Irred at the time, date and place, and due to the cause(s)								
M	29b. Signature and title of certifier	29c. License number 29c	29d. Date signed (Month, Day, Year)								
	30. Name and address of person who completed cause of death (Item 23a) ((Type, Print) He JV 1	29d. Date signed (Month, Day, Year) 6/19/10 2017 Ff Wash Rd.								
tate trar	31. Date filed (Month, Day Year) JUN 3 0 2010 August 9. Again	Les de la company de la compan									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 21844 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 2010 Keathe Moessner June 5:35 AMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville National Lutheran Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Octoor 2 Day, Year 9 1 0 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 506-01-5272 99 German Yrs Director Usual Residence of Deceden 10a, State 10b. County 10c. City, Town or Location **Funeral Director** 10d, Inside City Limits Rockville Md. Montgomery 1 Yes 2 ☐ No 10f. Zip Code 20850 10e. Street and Number 9701 V 10g. Citizen of What Country? Veirs Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 1 Yes 2 No Specify Specify: White 3 Midowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Karl Keil Anna Keil Brettsneider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Veirs Dr., Rockville, Md. Frank McGovern- Executor 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crem. 20a. Method of Disposition 20c. Location - City or Town, State 1 \square Burial 2 $\overset{\bullet}{\mathbf{X}}$ Cremation 3 \square Removal from State 6/27/2010 Alexandria, Va. 4 Donation 5 Other (Specify) Signature of Funeral Service Lie 22. Name and Address of Facility 2222-Wisconsin Washington,DC 20007 Will Hysong Co., Inc-. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause in each line the death. Do not enter Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ue to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or i imjury Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 1 N 2 🗌 No Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) 1 🗌 Yes 2 □ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗀 No

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

within 24 hours after deaun.

To the Funeral Director: After this and any and a filled in by the funeral di

Registrar

31. Date filed (Month, Day, Yea State JUN 3 0 2010

☐ Accident☐ Suicide

4 Homicide

29a. Certifier

(Check

2 [] 3 []

29b. Signature and title of certifier

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Charles W. Karesh 9701-Veirs Dr.,

32. Registra s Signa

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Rockvill(, Md. 20850

Medical

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Mark Edward Nejako 11:40 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 17813 Tree Lawn Drive Ashton Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) PA 1 🗷 M 2 🗆 F Days Sept. Day Year) 189-26-5984 79 **Director** Usual Residence of Decedent · 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No MD Montgomery Ashton 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? 23a Funeral 20861 USA 17813 Tree Lawn Drive items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces? þ 1 Never Married 2 X Married ō 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give "natural", Year or Dates. 1952-54 3 Divorced 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Public Schools Principal traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Adam Nejako Pauline Cecilia Puhlick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17813 Tree Lawn Drive, Ashton, MD 20861 Nancy J. Nejako/Wife other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it injury or (1 Burial 2 Cremation 3 Removal from State June 25 Alexandria, VA Metropolitan Crematory 4 Donation 5 Other (Specify) 21. Signature Euneral Service Licensee Francisdons of Tilins Funeral Home Inc. any 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate
Interval Between
Onset and Death
10 mos• Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Lymphoma Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): aftending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 🗌 No ed by the a detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been sig page 2 should b 1 Yes 2xx No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? certificate | 2 No 1 Tes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director; Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \nwarrow Residence 6 \square Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1X Natural 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) D61083 June 25, 2010 who completed cause of death (Item 23a) (Type, Print) MD 9707 Medical Center Drive, #300, Rockville, MD 20850 Thambo.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 21846 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 3, 2010 0456 hrs Medical Examiner Kavla Marlene Neff 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland Days Hours Director 218-08-9492 March 31.1983 27 2 X F 1 M Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No , or items 23a or 28a-f show r must be notified at once. Maryland Washington County Maugansville death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13813 Maugansville Rd. 21767 U.S.A. Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of
Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", so
injury or other traumatic event, the Medical Examiner. White If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Certified Nursing Assistant Nursing Home Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse C. Cline Lola Darlene Pennington Cline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ္ 19a. Informant's Name/Relationship (Type, Print) Jesse C. Cline- father 219 Humbird St. Cumberland. MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 7-8-2010 Smithsburg, Maryland Smithsburg Crematory Donation 5 Other Specify. 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Cardiac Arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): biventricular dilatation with left ventricular b. hypertrophy and interstitial and perivascular myocardial fibrosis Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi The law requires that the death certificate be executed Physician/Medical AMENDED 23a,b,pt.II, 27 per me g906 8-17-10 vt **X** UNPENDED Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Š 1 Yes 2 No 3 Probably 4 V Unknown Chronic Asthma Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 24 hours after death. 25 Was case referred to medical 26.Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Director: 5 Pending 1 Yes 2 No 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be or Town, State) ___ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 3, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Near 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21847 Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year DELBERT C. OVERBAY July 2010 7:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 80 Skyline Drive Conowingo Cecil 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 M 2 D F Months Days Hours **Director** 223-46-5688 72 11937 Pennsyl vania Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location the Maryland Director 10d. Inside City Limits MD Cecil Conowingo 1 ☐ Yes 2X☐ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ıral", or items 23a o with 1 Funeral 80 Skyline Drive 21918 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ ★o Specify: White "natural", Specify: Completed 3 Vidowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Manufacturing Unknown other traumatic event, Be Maryland filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ည Raymond Corbitt Overbay 1 and 2 should be f Health and Ment Margaretta Croy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Dennis A. Overbay/Son Skyline Drive, Conowingo, MD 21918 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō Important: If if any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Vernon Cem. 7/9/2010 Whiteford, MD Signature of uneral Serv 22. Name and Address of Facility C. Kober Harkins Funeral Home, Delta, PA 17314 23a. Part 1. Enter the diseas shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) oronava Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) transit Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician e hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 TI No ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2X No 1 Yes To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 7 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. injury Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) within 24 hours a Medical 29a. Certifier 1 🔀 🗲 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signate 29c. License number 29d. Date signed (Month, Day, Year) e and address of person who completed cause of death (Item 23a) (Type, Print) ~~0, DVIA 32. Registar's Signature State

200

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Quimby Jumer 28. 2010 12:30 A M Physician/ Helen Virginia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton Prince George's Southern Maryland Hospital 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Days 89 Hours 2/25/1921 North Carolina 577-22-0647 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho uny or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes X X No Temple Hills Prince George's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20748 3505 29th Place Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 K No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Home 12 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Green Annettie James Fortune 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 20748 3505 29th Place Temple Hills, Maryland John Quimby / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State Maryland Vet. Cem. 07/01/2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilitieorge P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 2074 21. Signatu 20745 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death 23a. Part V Enter the disease, r complications shock, or heart failure. List only one cause Immediate Cause (Final Physician/ emia disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Unknown Yes 2 X XVo 1 Yes 2 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed' certificate B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🔀 No Other: ျ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: work?
1 Yes 1 X Watural 5 Pending 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined KIX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number D0052999 29b. Signature and ti 29d. Date signed (Month, Day, Year) Raluman MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 10403 Hospital Drive G-06 CLINTON MD20735

Registrar

State

32. Registrar's Signature

RAHIMIAN

31. Date filed (Month, Day, Year

JUN 3 0 2010

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

	7 00016.	yu	239 E	. Main St. E	LKCOH, FIL	21921					
	The same of the sa		d of Head	e of dying, such as cardiac o	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death				
	b.	s to (or as a consequence or	<i>j</i> .								
ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
Examiner	cause Enter Underlying Cause										
хап		e to (or as a consequence of):								
	d										
Physician/Medical	UNPENDED X A	MENDED #23a ntT	nerMF G906	5.8/6/2010.WS	!						
Me		23c. If yes, outcome of pregr		7,07072010,WL		23d. Date of delivery					
an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	n 3 Ectopic pregna	ancy	Month D	ay Year				
ici	4	4 Pregnant at time of dea	ath 5 Other (Sp	ecify)							
ķ		9 Unknown									
Completed by					1 Yes	2 No 3 Proba	ably 4 Unknown				
ete					24a. Was an		opsy findings available				
ld I					autopsy performe		ompletion of cause of				
Ö					1 Yes 2	No 1 Yes	2 No				
Be (25. Was case referred to medical examiner?			26.Place of Death (Check	only one)						
70	1 ✓ Yes 2 No				<u> </u>	sidence 6 🗸 Other:	Scene				
	27. Manner of Death	28a. Date of Injury (Month, Day,Year) FOUND:	28b. Time of Injury	28c. Injury at Work?	28d. Describe how Subject shot s						
흹	Natural 5 Pending Accident Investigation	Jun 28, 2010	FOUND: 1603 hrs	1 Yes 2 ✔ No	oubject shot s	Cii					
اق	3 ✓ Suicide 6 Could not be	28e. Place of Injury - At ho		y, office building, etc.		et and Number or Run	al Route Number, City				
Medical Certification:	4 Homicide determined	(Specify) A residence	•		or Town, State 16 Barksdale Co	∍) urt, Elkton, MD					
2	29a. Certifier 1 Certifying Physician:	To the best of my knowledg	e, death occurred at th	ne time, date and place, and	I due to the cause(s) and manner as state	d.				
ij	one) 2 Medical Examiner: Or	the basis of examination ar	d/or investigation, in m	ny opinion, death occurred a	at the time, date and	d place, and due to the	cause(s)				
ğ	29b. Signature and title of certifier	d manner stated.	29	9c, License number	2	9d. Date signed (Mon.	th, Day, Year)				

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 29, 2010

Registrar

Assistant Medical Examiner

aroe Halloin

Carol Allan, MD

State 31. Date filed (1971) Day, 2010

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2010 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jume 23 P2010 Year **Physician** 12noon_M Rakhmanova Yekaterina /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Gaithersburg #507 17060 King James Way If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 11/28/1918 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours Ukraine 214-37-3363 Director 91 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD Montgomery Gaithersburg 1 ☐ Yes 21 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 17060 King James Way #507 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 2 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgiy Birukov Maria Birukov 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muse Aliyev/grandson-in-law 12823 Tern Drive Gaithersburg, Md. 20878 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐Cremation 3 □ Reparoval from State Washington, D.C. 6/25/2010 Rock Creek Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu PHITE IP Ad B SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Acute heart failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive heart failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-transit Respiratory insufficiency Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. ed by the a 9□Unknown 9 Unknown been signed by should be detac The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, chronic obstructive pulmonary disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an history of pulmonary embolism has autopsy performed? 1☐ Yes 2 No 1 ☐ Yes 2 ☐ No coronary artery disease Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည ospital or Attending Phynous after death.
Ineral Director: After this y filled in by the funeral di 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 💢 Certifying Physician: 环 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 ☐ Medical Examiner 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46366 June 25,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Policy Cokoleky M D 11119 Rockville Pike Rockville Maryland Felix Sokolsky M.D.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 28 2010

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien® 0.10

			1 - State of Maryland / Dep	artment of Health and M ertificate of Death	ental Hygien	2010	21851						
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Axel Rivas		2. Date of Death Month	L 2010	3. Time of Death						
~~ 1	Examin		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Sprii	4	c. County of Death							
-e-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	Montgon 9. Birthp	place (State or Foreign						
ŀ.	Director		none 1™ 2□F Yrs. Usual Residence of Decedent	Williams Bays Hours 188	06 22 2	Olo Mai	ryland						
	aryland show	-	10a. State 10b. County 10c. City, Town or L	ocation ersburg		1	0d. Inside City Limits 1 ☐ Yes 2 No						
	r 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Cour							
	ath with	ral D	5030 Brookville Road	20882		USA							
9	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Evarinee rust be notified at	Funeral	1 P Never Married 2 Married 1 Tyes 2 No	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.						
2-0036	hours a	ed by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1⊠Yes 2⊡No <i>Specify:</i> El Salvado edent's Usual Occupation		Specify: Wr Kind of Business/In-	nite						
215	thin 72 ho e. an "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workir DO NOT use retired)	ng Tob.	Kind of Business/in	dustry						
7	iled wil Hygien ther th		0 17. Father's Name (First, Middle, Last)	none	(First, Middle, Maide	none							
lan	be od o	To Be	Manuel Esau Rivas Lopez				es Chavez						
Maryland	bus E			ing Address (Street and Number or Rura 0 Brookville Rd									
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemelery, crematory or other place) 20b. Location - City or Town, State 4 Donation 2 Other (Specify)) 20b. Place of Disposition (Name of cemelery, crematory or other place) 20c. Location - City or Town, State 20c. Lo										
Baltii	permit. F Departm Importar any injur		21. Signature of Puperal Service Licensee	HIMIP AD RETWALDI 241 Columbia Bly	FUNERAL	SERVICE	E,P.A.						
			23a. Part 1. Enter the lisease, or complications that caused the death. Do not el shock, or heart failure. List only one cause on each lin			r spring	Approximate Interval Between						
	Physician /Medical		Immediate Cause (Final disease or condition	E DELLING			Onset and Death						
	Examiner		Due to (or as a consequence of):	3 WEEKS EGA									
	tec	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
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ROX	ding ding se as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the part 13 modifies 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	☐ Ectopic pregnancy			3d. Date of delivery						
	the death of the attenched for us	ysici		Other (specify)		Month	Day Year						
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VITal	Physician: r this certific raf director, I	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death	(Check only one)								
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<u>≥</u>	al or Al	Certification:	3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Hur ate)	al Houte Number,						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Medical C	29a. Certifier (Check only one) 1 Certifying Physic an: To the best of my knowledge, dea (Check only one) 2 Medical Examine: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as and place, and due t	stated. to the cause(s)						
	To the within To the compl	Me	29b. Signature and title of certifier	29c. License number	29d. E	Date signed (Month,	Day, Year)						
	2		20. Name and address of ourses the completed course is in the life.	1944 tq	- 6	1/27	110						
			30. Name and address of person who completed cause of death (Item 23a) (Type Darryn Marc Band MD 1500	Forest Glen Rd	Silver S	Spring,M	id 20910						
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 8 2010 Server A. Again	R.P									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 20b per FH G905 7/13/10 dk
State of Maryland / Department of Health and Mental Hygiene 21852 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ July 6. ^D**2**010 Erwin Saunders 1:30 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Country Meadows of Frederick Frederick Frederick 5. Social Security Number 6. Sex. 1 X M 2 □ F 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign County) York **Funeral** Months Hours Min. June 18 , 1923 095-14-3110 87 Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5955 Quinn Orchard Road 21704 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 ☐ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Industrial (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Marketing/Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Arthur Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Brian Saunders / Son</u> W. _Washington Blvd., Oak Park, IL 60302 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place injury or 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 7/9/2010 Smithsburg, Maryland 21. Signature Furieral Service License Reeney Adnid of Bassford PA Funeral Home any MO1473 106 E. Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or conshock, or heart failure. List only polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) HIPOXIB nute Medical Due to (or as a consequence of) Examiner END OPD STACE contrans Sequentially list conditions, Examiner if any leading to immediate cause. Enter Underlying veleted To the Hospital or Attending Physician: The law lequires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) care has t een signed by the attending physician page 2 should be detached for use as the burial Be Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ypertension Division of Vital Records, 2 No 3 Probably 4 Unknown Hyperlipidemic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Certificate: To 1 🗌 Yes 2 💢 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending Investigation 1 🗌 Yes 2 🗆 No Suicide 6 ☐ Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) A Hussai 04686 6/ 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAA 2 A. DRIVE 21702 HUSSAIN. FREDERICK 31. Date filed (Month, Day, Year, 32. Registrar Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	/laryland	-	ertment of Tificate of		and M		giene	010	218	353
			Decedent's Name (First, Middle, Las	")	-					2. Date of Dea	ath	Year		of Death
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	Funeral		5. Social Security Number 6. Se	x ∃M 2□ X F ^{7. A}	Age (In yrs. Ia 9		If Under 1 Year Months Days		Min.	8. Date of Birt (Month, Da July 18	n y, <i>Year)</i> 101	9. BI	rthplace (State country) M	_
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	or 284	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What C	ountry?	
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	72 hours after death with the Maryland Instural", or Items 23a or 28a-f show Unal Examiner must be notified at	Funeral	11. Marital Status	12. Was Deceden Armed Forces	3?	3. 13. \	Was Decedent of f Yes, specify Cul	Hispanic Ori pan, Mexicar	igin? (Spe n, Puerto	ecify Ye's or No Rican, etc.)	1	 Race - Am Black, Whi 	erican Indían, ite, etc.	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Microsoft Americal 2 ☐ Married	1 □Yes 2 □ If Yes, Give			I∐Yes 2∭XNo	Specify:	;			Specify: 1.1	hite	
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	at Hyg othe	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,	Maiden S	Surname)		
/lar	uld be Menta Irked	70 E	Henry Green					Ber	tha	Biddle				
Maryland	l 2 should be filed within 7 h and Mental Hygiene. r is marked other than " traumatic event, I'm Med	ľ	19a. Informant's Name/Relationship (7	,			g Address (Stree				er, City or	Town, State,	Zip Code)	
	and and and and and and and and and and		Shirley Mercer/ N	iece			Bow St.						Otata	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, I'm, Martical Examiner must be notified at once.		20a. Method of Disposition 1 ➡ Burial 2 ➡ Cremation 3 ➡				sition (Name of natory or other pl anor Mem		7/1/ Park	2010		ton, M	r Town, State	
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	0		30. Name and address of person who	completed cause of	f death (Item	23a) (Type,	Print) - F/1-X	HAT	LA	CKT	ATE	L nd)	21911
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Month 21:15 PM Physician/ Margaret Schultz June 2010 Medical 4a. Facility Name (if not institution, give street and number, or Location of Death 4c. County of Death 4b. City. Town Examiner Montgomeru Hospital Olney Montgomery teneral 9. Birthplace (State or Foreign If Under 1 Year Under 24 Hrs. 8. Date of Birth (Month, Day, Y Aug 23, Social Security Number Funeral Min. Year 1925 Months Hours 203-14-9208 1 M 2 St F Pennsylvania Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a State Director or than "natural", or items 23a or 28a-fs the Medical Examiner must be notified 1 Yes 2 No Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20853 USA 14004 Flint Rock Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ₩ No Specify: Specify: White 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file
Department of Health and Mental h
Important: If item 27 is marked of
any injury or other trainments Emma Morrow ည James O'Neill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14004 Flint Rock Road, Rockville, MD 20853 19a. Informant's Name/Relationship (Type, Print) Nancy Oakes/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 27 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metropolitan Crematory 2010 Alexandria, VA 4 Donation 5 Other (Specify) Funeral Service Lighnses Trancol Address of Collylins Funeral Home Inc. 500 University Blvd. W. Silver Spring. MD 2090 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Examir or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events nummia and resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 욘 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 \square Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Bichhuon 54996 2010 26 June 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Drive, Olney 18101 Vinh rina Dichhuono Day, Year) 31. Date filed (Mg 2. Registrar's Signature

State

Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 24, Charles E. Somerville 2010 7:05 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** New York Min. 1 2 M 2 D F Months Days Hours April 17, 1920 Director 084-10-0536 90 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ื No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3005 South Leisure World Blvd., #720 20904 USA death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

14 Yes 2 If Yes, Give Black, White, etc. 9 1 Never Married 2 Married 2 🗆 No within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White "natural", 3 X Widowed 4 Divorced Completed the Me jical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) other than College (1-4 or 5+) Sales Telecommunications Be filed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles F. Somerville Mary Jorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Nicholson/Daughter 12344 Sherwood Forest Drive, Mt. Airy, MD 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State June 28, Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2010 Silver Spring, Maryland Signature of uperal Service 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arteriosclerotic Cardiovascular Disease disease or condition 2 months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth 2 Live 3 1 4 Pregnant at time of death in the past 12 months? Month Year Yes 2 No the detached 9 Unknown 9 Unknown P.O. been signed by should be detac Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Chronic Renal Insufficiency, Pneumonia of Vital Records, Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 Yes 2 No Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cther (Specify) 2 1 No ပ 1 🗌 Yes 1 Inpatient 2 X ER/Outpatient 3 IDOA funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred : After 1 (Month, Day, Year) Natural 5 Pending Division death. 1 Tes 2 No Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24543 10 June 25, 2010

State

Registrar

3305 N. Leisure World Blvd., Silver Spring, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

James A. Rossi, MD

28

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10g per FH 6905 /13/10 dk

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 3:18 Fred Willard Shoemaker A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 2-24-1916 1 🗓 M 2 □ F Days Hours 94 West Virginia 232-26-0307 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🎇 Yes 2 □ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 18 W. Wilson Blvd. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11, Marital Status Black White etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Schools | Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Laura E. Leatherman Daniel M. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21740 14727 Daley Road Hagerstown, Md Jerry Shoemaker, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) un State 7-9-10 St. Luke Romney, WV 21. Sign that of Juneral Service Lic. WV 22. Name and Address of Facility Romney, 26757 McKee Funeral Home 115 E. Birch Lane 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause peach line.

Immediate Cause (Final Approximate Interval Between Physician, disease or condition resulting in death) Medical (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or ilnjury Due to (or as a consequence of for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ ER/Outpatient 3 DOA 1 Inpatient 2 🗆 27. Mann Deat 28b. Time of 28c. Injury at work? Certificate: 28a. Date of injury 28d. Describe how injury occurred Natural 2 ccident (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 <u>Certifying Nurse Practioner</u>: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the title of certifier 29d, Date signed (Month, Day, Year) 29c, License number 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) MEADOWIEN DR egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year JulyPhysician/ Patricia Ann Shorday 6 9:10 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 22240 Jefferson Blvd. Smithsburg 5. Social Security Number 8. Date of Birth (Month, Day, OCt. 20 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Months 1 M 2 X F Hours 186-32-2091 69 Country) Pennsylvania Director Yrs Oct. 1941 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2X No Smithsburg Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22240 Jefferson Blvd. 21783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. Yes 2 X No Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Coffee 12 Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dorothy Miller Henry Pfieffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22240 Jefferson Blvd. Smithsburg, Maryland 21783 Earl A. Shorday 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 9 permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. 1 Durial 2 X Cremation 3 Removal from State Smithsburg, Maryland Smithsburg Crematory 4 Donation 5 Other (Specify) 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cinco disease or condition UNG Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the t IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes Completed 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, Miloun 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Compro Cormeck 31. Date filed (Month, Day, Year 32. Registrar State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ $\mathtt{Ju}^{\mathtt{Month}}_{\mathbf{n}\mathbf{e}}$ 2ª2. 2010 3:45 GLORIA M. THOMAS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bradford Oaks Nursing & Rehabilitation Center Prince George's Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Year) 929 Arnold, August, Day, 1 - M 2 X F 80 577-42-6056 Md Director Usual Residence of Decedent shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 ☐ No Prince George's Fort Washington Md 10a, Citizen of What Country? 10e Street and Number USA Funeral 20774 1800 Palmer Road, Suite #200 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify. If Yes, Give "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12th Secretary vear Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mabel Brice James Edward Milton, Sr. should and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 19a. Informant's Name/Relationship (Type, Print) 1800 Palmer Road, Suite #200, Ft. Washington, MD 1 and 2 s of Health a item 27 Linda J. Hicks, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State July 3, 2010 Suitland, MD Washington National 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence or, n any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit Exam that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ____ Year Month Day page 2 should be detached g Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Records, TYPE 2 DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 2X No Yes 2 K No of Vital To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury 28c, Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 Pending Division 1 Yes 2 No M Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 24 hours Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a June 29, 2010 D0052999

State

Box 68760

DHMH 17 Rev 7/2009

Registrar

10403 Hospital Drive, G-06, Clinton, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ali Rahimian, MD,

31. Date filed (Month, Day, 1507) JUN 3 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Physician/ JUNE 24 P^{M} VENDALINA ANNETTE TOMLINSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 8. Date of Birth 9. Birthplace (State or Foreign '. Age (In yrs. last birthday) **Funeral** Days 8/7/1911 1 □ M 2 🛣 F Panama, Canal Zone **Director** 98 114-24-9180 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗆 No Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2501 Musgrove Road 20904 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Domestic Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alfred Tomlinson / Son Lubentia Ct. Largo. Marvland 20774 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan 6/28/2010 Alexandrai, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) RESPIRATORY FAILURE Medical Due to (or as a consequence of) Examiner INTERSTITAL LUNG CANCE Sequentially list conditions, Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown in the past 12 months? Year Month Day Pregnant at time of death 2 💢 No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? ANEMIA 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 24 hours after death. Funeral Director; After this npleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination arrow investigation, in my spanish, and the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within 2 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day. Year)

State Registrar

31. Date filed (Month, Day, Year)

JUN 3 0 2010

32. Registrar's Signature

Satyam Ashvin Kumar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road Silver Spring, MD 20910

010

10-04689 Cindy Sue Walker Amend Item 21 per FH C905 7/13/10 dk
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2010 21861

		1- For State Registrar			Cer	tificate	of Dea	ath			Re	eg. No.	1 0	21001
Physicia odical Exami	an/	Decedent's Name (First, Midd		CINDY S	SUE WAI	LKER					. Date of Deat Month June 21, 2	Day Ye	ar	3. Time of Death 2018 hrs
		4a. Facility Name (if not institution 312 Crusada Road 3	_			Apt 20		y, Town, or Lo	ocation of	Death	· ·	4c. County Dorche		
Funeral		Social Security Number	6. S ex		Age (In yrs. la			nder 1 Year	If Under:	24Hrs.	8. Date of Bin	th(MM/DD/YYY		hplace (State or
Director		214-70-5642	1 M	2 x F	50	,	rs. Moi	nths Days	Hours	Min.	6/2	2/1959	Foreig	MARYLAND
any		Usual Residence of Decedent 10a. State 10b. County			10c. City,	Town or Loc	ation							10d. Inside City Limits
ınd show aı nce.	5		RCHE	STER				CA	MBRII	DGE				1 X Yes 2 No
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene a ment of Health and Mental Hygiene is an arked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be potified at once.	Director	10e. Street and Number 312 CRU	SADEF	R RD., A	PT. 203		10f.	Zip Code	21613		1	0g. Citizen of W	hat Cour US	-
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fter de	y Fu	3 Widowed 4 Div	orced If Ye	Yes es, Give Year	2 🔀 No	1[Yes	2 🔀 No	specify:			Specify:		WHITE
hours after natural", c	d by	15. Decedent's Education (Spe	cify only hi	ghest grade	completed)			ual Occupetion				16b. Kind of B	usiness/l	ndustry
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MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medisa	Be C	17. Father 5 Haine (First, Middle		ES E. WA	ALKER					,		LIS L. FR.		?
D 2121; should be fil and Mental F 7 is marked natic event, i	70 5	19a. Informant's Name/Relations	hip (Type,	Print)		19b. Mai	ling Addre	ess (Street a	and Numb	er or Ru	ral Route Nun	nber, City or Tox	vn, State	, Zip Code)
MD d 2 sh lith an n 27 i		PHYLLIS FRAZI	ER-JAN	1ES / MO							A AVE., N	MADISON.		
ore, Mes I and 2 of Health If item 2		20a. Method of Disposition 1 Burial 2 Cremation	n 3 🔲 F	Removal fron	n State	crematory or	other pla					1	•	
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Baltimo permit. Page: Department o Important: injury or oth		21. Signature of Funeral Service Todd Mielke pe		MO15/	47				•	EDAL	HOME PA	308 HIGH S	T CAN	IBRIDGE, MD 21613
Physician	_	23a. Part I. Enter the disease, or	complicati	ions that cau	sed the death.									Approximate Interval Between Onset and
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Examiner		or condition resulting in death)			onsequence o		,							
	P.	Sequentially list conditions, if any, leading to immediate	b Due	to (or as a c	onsequence o	f):								
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Records, P.O. Box 687 The law requires that the death certific cate has been signed by the attending page 2 should be detached for use as t	Physician	past 12 months? 1 Yes 2 No 9 Un	known 4	Pregnar	nt at time of de		Other (S							
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Vita ysicia his ce direct	To Be	examiner? 1 ✓ Yes 2 No	Hosp	ital: 1 Inj	patient 2	ER/Outpati	ent 3	DOA	Other 4	Nursing	Home 5	Residence 6	✓ Other	r: Scene
_ = <2	on: T	27. Manner of Death	ding	28a. Date of (Month, I	f Injury Day,Year)	28b. Time	of Injury	28c. Injury	at Work?		28d. Describe	how injury occu	rred	
Division tal or Attendiurs after death. The Director: A led in by the fi	icati	2 Accident Inve	stigation	28e, Place	of Injury - At h	ome, farm, s	treet, fact	tory, office bu	ilding, etc.	. 2			ber or Ru	ıral Route Number, City
Div pital or ours afte reral Dir	Certification:		ld not be ermined	(Specify)							or Town, S	State)		
Division Division The Hospital or Attend The Hours after death, The Funeral Director: The Funeral Director:	edical C	29a. Certifier 1 Certifying F	aminer:On	the basis of	examination a	ge, death o	curred at	the time, date my opinion,	e and placed	ce, and d	lue to the cau	se(s) and mann and place, and	er as stat	ed ne cause(s)
To the within 2 To the complet	Med	29b. Signature and title of certification	and	d manner sta	ted.			29c. License		_				nth, Day, Year)
		Willia B	renni e	11 11	D			O.C.M	1.E.			June 22,	2010	
		30. Name and address of perso						O		145.5	14004			
]		Melissa Brassell, MD			ical Exami		1 Penn	Street, Ba	altimore	, MD 2	1201			
S	tate	31. Date filed (Month, Day, Year	D SANGE	1 /-2	istrar's Signat	леу	Soud	20						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 21 per in g905 7-13-10 vt.
State of Maryland / Department of Health and Mental Hygien 0 1 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician 2010 Gilbert /Medical 4c. County of Death Town, or Location of Death acility Name (If not institution, give street and number) 4b. City, **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Yea Nov 24 If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number Sex XXM 2 □ F **Funeral** Months 1942 Wytheville, 226-52-3229 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c City Town or Location 28a-f show must be notified at Morris Township, Alexandria 1 ☐ Yes XXNo PA Huntingdon Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ŏ 6612 Hidden Hills Lane items 23a 16611 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black White, etc. 1965/66 1XXes 2 If Yes, Give Year or Dates: 1 Never Married XXMarried Baltimore, Maryland 21215-0036 o, 1 Yes 2000 Specify: white þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) 12 College (1-4 or 5+) truck driver construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Louie Edward Wolfe is marked Melvie Scott ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mrs. Joyce A. Wolfe (wife) 6612 Hidden Hills Lane, Alexandria, Pa 16611 20b. Place of Disposition (Name of cemetery, crematory or other place)

Alexandria Presbyterian Cemetery, Alexandria, PA 20a. Method of Disposition permit. Pages 1
Department of H
Important; If iter
any injury or ott XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Carlton C. Douglas Name and Address of Facility PO Box 594 16652 Folter 188 L Cutright Funeral Homes, Huntingdon, PA 23a, Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ruptured abadminal apric angurysm **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Live birth 2 Fetal death Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death I Director: After to in by the funer 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 Accident Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -M.D. RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) van ka ta Narla 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

dRW 12 Regis

1	For State of Ma 1 - State Registrar		epartmer <i>Certifica</i> :		lealth and M Death		gien Reg. N	2010	21863
	1. Decedent's Name (First, Middle, Last)	, ,				2. Date of De Month		ay Year	3. Time of Death
ian cal	Dorothy L Wome	LSKI				Ğ	2	3 2010	
ner	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				Location of Death Frederic	ς		c. County of Dea Calvert	th
	5. Social Security Number 212−28−2231 6. Sex 1 M 2X F 8	e (In yrs. last birth $1 $	nday) If Unde Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 10–21 –	av. Year	r) Co	thplace (State or Foreign buntry) nesota
	Usual Residence of Decedent	10c. City, Town							10d. Inside City Limits
<u>~</u>	10a. State 10b. County MD Calvert	Lusby	or Location						1 □Yes 2 MNo
ect	10e. Street and Number	Базоу	10f 7i	p Code			10a C	itizen of What Co	ountry?
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ner	11 Marital Status 12. Was Decedent	Ever in U.S.	13. Was Dece	dent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No)-	14. Race - Ame Black, Whit	
Be Completed by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Y 1 Yes, Give 2 Married Year or Dates:	No	1 ☐ Yes		Specify:	nicari, etc.)		Consiliu	hite
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ig m	Elementary/Secondary (0-12) College (1-4or 5)+)			during most of work		IIo	moma leo se	
ပိ	12 17. Father's Name (First, Middle, Last)	HO	usewife	3	18. Mother's Name	e (First Middle		memaker	
To Be	Chad Martin				Emily S			or Jamano,	
-	19a. Informant's Name/Relationship (Type. Print) Laura Bryan — Daughter				and Number or Rur aks Trail				
	20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of cemetery	Disposition (Na v, crematory or	me of other plac	matory 6/2	Date 24/2010		Location - City or	Town, State
	21. Signature of Funeral Service Licensee	1100202	22. Name a	ind Addre		Rausch	Fun	eral Hon	ne, P.A.
	23a. Part 1. Enter the disease, or complications that caused	d the death. Do no							Approximate
	shock, or heart failure. List only one cause on each li	ne.							Interval Between Onset and Death
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Examiner	Cause (Disease or injury that initiated events c.		Δ).						9.575
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by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	2 Fetal death	3 ☐ Ectopic 5 ☐ Other (s		Sy			23d. Date of do Month	elivery Day Year
y Ph	Part II. Other significant conditions contributing to death b	out not resulting in	the underlying	cause giv	en in Part I.	23e. Did	tobacc	o use contribute	to the cause of death?
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Completed						perf	ormed?	death?	_
Be	25. Was case referred to medical examiner?				26. Place of Deat	th (Check only	one)		
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ion	27. Manner of Death 1 Natural 2 Accident 28a. Date of Inju (Month, Death)	ay, Year)	njury M	28c. Inju Wo	ryal rk?]Yes 2 □No	28d. Describe	I IIOW III	jury occurred	
ficat	ZENACOGOTI	jury - At home, far tc. <i>(Specify)</i>			1,00 = 2,10	28f. Location	(Street	and Number or I	Rural Route Number,
erti	4 Homicide determined building, et	tc. (Specify)				City or To	iwn, St	ate)	
Medical Certification: To	29a. Certifier 1/2 Certifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis of and mangers.	of examination and	, death occurre d/or investigation	d at the ton, in my	ime, date and place opinion, death occu	, and due to th rred at the time	e cause e, date a	e(s) and manner and place, and di	as stated. ue to the cause(s)
Me	29b. Signature and title of certifier		29	9c. Licen	se number		29d. l	Date signed (Mor	nth, Day, Year)
				Do	061783		6	/24/20	010
	30. Name and address of person who completed cause of 100 Host	oeath (Item 23a) (Type, Print)	nce :	Frederick	, MD 20	0678	3	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2010 A M 4:27 JESSE E. WILLIAMS, JR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles **Hughesville** 6835 Barney Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Hours June 22, 1928 1 **X** M 2 □ F Washington, DC. 82 Director 579-30-3651 Usual Residence of Decedent Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 XYes 2 No Hughesville Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20637 6835 Barney Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes f Yes, Give þ 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Year or Dates. 1945–1947 White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Government 10 Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Virginia White Jesse E. Williams. Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6835 Barney Drive Hughesville, Maryland 20637 Steven E. Williams / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 06/28/2010 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, Maryland 20676 M01206 Kyle S. Simons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauce. E. to Julying Cause (Disease or iinjury Examine Due to (or as a consequence of) ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: Of the basis of examined and of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6-28-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) drw 10 California, Maryland 20619 Minal Shah, M.D. 23415 Three Notch Road, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State backer JUN 2 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8:20 P M Louis Winer 2010 Medical Tuna 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Manor Care Springhouse Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yeav 18, 1 🛛 M 2 🗆 F 579-16-5870 89 Director Washington, DC May Usual Residence of Decedent 3a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Dunkirk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a the Medical Examiner must b Funeral 6319 Johns Lane 20754 U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black White etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify If Yes Give White Specify: 3 Midowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Insurance 17. Father's Name (First, Middle, Last) of Health and Mental H of Health and Mental H of item 27 is marked ot ir other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) Albert Winer Sarah Lochtel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is Diane Citron/Daughter 6319 Johns Lane, Dunkirk, Maryland 20754 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State King David Cemetery Falls Church, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the diseas implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List ne cause on each line Onset and Death Years Immediate Cause (Final Physician/ Cardiomyopathy disease or condition resulting in death) , Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical P.O. Box 68760 IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Por in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, Hypertension Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? Hyperlipidemia 24a, Was an page 2 autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Assisted Living Hospital: 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniurv work? 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A completed filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🛮 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one 29b. Signature a title of certifie 29c. License number 29d. Date signed (Month, Day, Year) June 25, 2010 D28656

State

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Raui Passi, MD, 15245 Shady Grove Road, Suite #130, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year)
JUN 28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 21866 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12:47 P_M WALLACE JUNE 21^{ay} Physician/ 2010 FLAGGY Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number . Age (In yrs. last birthday) Funeral Days Hours PERRYMAN, MD 1 □ M 2 🛣 F 0771971931 78 579-14-8363 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location or 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant If Item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State Funeral Director PRINCE GEORGES 1 X Yes 2 □ No MITCHELLVILLE 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20721 USA 906 ARBOR PARK PLACE Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE FOOD SERVER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည KELL В. WILLIAMS LOTTIE WALTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1009 CLOVIS AVE. CAPITOL HEIGHTS, MD ALONZO WALLACE/ SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State JULY 28, 2010 ARLINGTON, VA ARLINGTON NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) JOHNSON & JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Live 20011 716 KENNEDY ST. NW, WASHINGTON, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final VERE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confidence. attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🏝 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2.1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 1 Tyes ျ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tit M. D 06/24/2010 D0062141 D. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. OLUMIDE COKER, 1221 MERCANTILE LANE, UPPER MARLBORO, MD 20774 32. Régistrar's Signature State JUN 3 0 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of M	aryiand		artment of F tificate of L		•	giene Reg. N	2010	21867
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State 10	b. County	2	10c. City,	, Town or Loc		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				10d. Inside City Limits 1 ☐ Yes 2 No
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	To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director, Fafer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical	(Check 2 📙 I	Medical Examin	ician: To the best of e	xamination :	and/or investi	igation, in my opinio	n, death occurred	at the time, date a	nd place	e, and due to the o	ause(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21868 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7 O Physician/ DON Mont 1 405 Medical 4c. County of Death ta. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Mandrin House for Hospice Harwood 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 123, 1921 New York 374-18-2805 89 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 220 concerning or other traumatic event, the Nacian process. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎇 No Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21409 U.S.A. 961 Dogwood Tree Drive 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Specify: White 1 ☐ Yes 2x No Specify: If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Population Reference College (1-4 or 5+) Elementary/Seconday (0-12) Bureau President & CEO Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ethel Sholtz Samuel Mark Avedon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 961 dogwood Tree Drive, Annapolis, Maryland 21409 Phyllis M. Avedon/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial Cremation 3 Removal from State ArdentCremationServices7-13-10 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 6009Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy signed by the atter in the past 12 months? Month Day Pregnant at time of death Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2, No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 1 Natural 5 Pending 40USE 2 \square No Investigation Accident Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 21438 holeted cause of death (Item 23a) (Tr

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 21869 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Dear 4c. County of Death YOM Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Rorth Carolina 8. Date of Birth 1 □ M 2 🖾 F Month Days Hours Min. (Month, Day, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3altimore 1 Gres 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3300 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify Specify: Black Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) mesti Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3300 20a. Method of D isposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State Talto 19-2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Service Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia disease or condition resulting in death) Sequentially list conditions if any leading to an modal cause. Enter Underlying Cause (Disease or iinjury that initiated events Mynertensim resulting in death) Last voscovan discerse IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

Physician/ Medical Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a o

the Medical

permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

death with the Maryland

within 72 hours after

Maryland 21215-0036

Baltimore,

To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Division of Vital Records, P.O. Box 68760

Physician/Medical Examiner Completed by Be Certificate: To

in the past 12 morth 1 Yes 2 No

1 Yes 2 9 Unknown

Suicide

4 Homicide

29a. Certifier

ie of pregnancy

eath 9 Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____

23d. Date of delivery Day

Part II. Other significant conditions	s contributing to death but not resulting i	n the underlying cause given in	n Part I

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an

prior to completion o death? 1 Yes 2 No

5. Was case referred examiner? 1 Yes 2		Hos	spital: 1
7. Mann of Death	5 Pending		28a. Date of inju (Month, Da

6
Could not be

ient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28b. Time of ury ay, Year) 28c. Injury at iniury work?
1 Yes 2 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

MD

Yes

(Check 2 ☐ Medical Examiner: On the basis of examination and/or investigation	on, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated
only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	007129	7-13-10

29c. License number 952749

26. Place of Death (Check only one)

TOWERN.

29d. Date signed (Month, Day, Year)

21204

30. Nar	ne and address of person	n who complete	d cause of death	(Item 23a) (Type,	Print)
7.	MRSARA	ma.			Drive

OSKY 505

State Registrar

Medical

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 s

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. NC. 10

		For State Registrar	State of M	arylan	-		of Health and of Death	Mental Hy	Reg. No.	010	21870
Physicia	an	1. Decedent's Name (First, Middle, L						2. Date of De Month	Day	Year	3. Time of Death
/Medic		Josephine			oughs			JULY		2010	1056 AM
Examin	er	4a. Facility Name (If not institution, g)			vn, or Location of Dea	ath		unty of Death	
		5. Social Security Number 6.	Sex 7.Ac	ne (In vrs	last birthday,		Year I If Under 24 Hr	s. 8. Date of Bi	rth	9. Birth	place (State or Foreign
Funeral Director		216-34-8434	1 □ M 2 □ X =	72	Yrs.	Months D	ays Hours Mir	s. 8. Date of Bi Month, D 0 8 / 1 4	y 1 9 3 7	Mar	yland
		Usual Residence of Decedent									
points ago, to theath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Exeminer must be notified at once.		10a. State 10b. County		10c. Cit	ty, Town or L	ocation					10d. Inside City Limits
a-fs	Director	MD N/	'A			Balti	more				1 y Yes 2□No
or 28	Jire .	10e. Street and Number				10f. Zip Co	ode		10g. Citizen	of What Cou	intry?
23a		5514 Rubin Ave	.			212				U.S.A	
erms	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	?	.S. 13.	Was Decedent If Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or Ne erto Rican, etc.)	0- 14,	Race - Ameri Black, White,	
in in	by Fi	1 Never Married 2 Married	1 ☐Yes 2X If Yes, Give	No			XNo Specify:		1	noifu	
ural"	g p	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:		l to Dec		\			Вта	
"nat	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	edent's Usual C e kind of work o DO NOT use r	done during most of w	rorking	16b. King c	of Business/Ir	ndustry
than	臣	Elementary/Secondary (0-12) 8th Grade	College (1-4or	5+)		sekeep	*		Priv	ate H	Omes
nt, #		17. Father's Name (First, Middle, La	st)		Hous	ereeb		ame (First, Middle			Omes
ed o	Be		ennis				Rose	Den		,	
mark	은	19a. Informant's Name/Relationship			10h Mail	ing Address (S	treet and Number or I			uwn State Zi	in Code)
7 is r traur		·									
em 2		Rosalind Evans 20a. Method of Disposition	(Niece)	20b. F	Place of Disn	osition (Name i	n Ave., Ba	Date		ion - City or T	
0 0		1 ☐ Burial 2 🖾 Cremation 3	☐ Removal from State	Jo	sephie	matery of other	r place)	112/10	D-14		MD
njur.		4 □ Donation 5 □ Other (Special Services Lie		An				/13/10		imore	
any In	(I)	21. Signature of Funeral Service Lic	N. Will	lear	ms 2	TOSSON 2140 N	ddress of Facility Of EUlton	wn Jr. Ave.,B	Funer altim	al Ho ore,M	me PA ID 21217
sician edical miner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Seguentially list conditions.	a. As s b.	ine.	quence of);	nter the mode o	of dying, such as cardi	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
physician and s the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Circle Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	4700	my for	ILUNE					3 mins
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 🗀 Feta	al death 3	□ Ectopic preg □ Other <i>(speci</i>			23d.	. Date of deli	very Day Year
0 0		Part II. Other significant conditions	s contributing to death t	but not res	sulting in the i	underlying caus	se given in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
d be	d by	CVA						1 🗆	Yes 2□N	lo 3□ Pro	obably 4 Unknow
should be	Completed	HTW						24a. Wa	l 2	Mh More aut	topsy findings available
2 2	ш	11117						– auto	opsy formed?	prior to c death?	completion of cause of
his certificate ha		DM						1 □ Yes	2 X No	1 ☐ Yes	2 □ No
recto	Be	25. Was case referred to medical examiner?	Hospital:				Othor	eath (Check only			
	P	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 ☐ Inpati		ER/Outpatie	ent 3 DOA	4 Linursing	Home 5 Res			cify)
within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral i	Certification:	Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	(Month, Di	<i>ay, Year)</i> ijury - At h	Injury	М	. Injury at Work? 1 □ Yes 2 □ No ffice	28f. Location			ral Route Number,
filled		29a. Certifier 1≱ Certifying	Physician: To the best	t of my kno	owledge, dea	ath occurred at	the time, date and pla	ace, and due to th	e cause(s) an	nd manner as	stated.
the Fur	Medical	(Check only 2 ☐ Medical Ex	aminer: On the basis and manners	of examina		nvestigation, in	my opinion, death oc		e, date and pla	ace, and due	to the cause(s)
To	Σ	29b. Signature and title of confier				29c. L	icense number			igned (Month	
1		1	2				D007071	3	200	4 8.	2012
V		30. Name and address of person wh	no completed cause of				C 1-	A > 100	Z 1	L # #2	#15
Stat	to	31. Date filed (Month, Day, Year)	32. Regist	ravis Signa		700	CATON	AV	Brictin	NOVY	MD
51(8)	æ l	(- Signi							

A. Aarts
ORIGINAL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ຶ່ລ ເປັນ Bruce 34M Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/Amore 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🏻 F Hours Maryland Director 214-26-2469 77 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore N/AMD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 4010 Chatham Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X**No 1 🗌 Yes 2 🔀 No Specify: black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Data Entry Ceritium 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Parker Grace Bruce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Pine Place, Baltimore, MD 21236 Carlton Smith(son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Joseph Brown H And Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/12/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22Josephdreff of Fabrown Jr. Funeral Home PA liamo 21217 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Prysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be def ģ Division of Vital Records, 2 No 3 Probably 4 Unknown breast 1 Tes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation ☐ Accident Sulcide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner To the best of my knowledge at the fline, date and plane and due to the neuro(s) and the nor as static 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 2401 Raltimore

Registrar

31. Date filed (Month, Day,

MID ZIZIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ora Lee Brooks 9:53 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Union Memorial Hospital Baltimore 8. Date of Birth
(Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) N.Carolina 7. Age (In yrs. last birthday) Funeral Days Min. 1 M 2 5 Hours Director 144-30-8457 72 1938 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Randallstown Maryland 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21133 USA Apt. 221 5107 Old Court Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian . or Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black "natural", 3 XWidowed 4 ☐ Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Head Cook Year 2thgrade permit. Page 1 and 2 should be filed win Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>the</u> once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Georgia Mae McRay James Frederick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Buie/Daughter 9017 Bruno Court Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 7/151/2010 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem. Signature of Funeral Servic Lenses 22. Name and Address of FacilitChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore,MD 21215 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ dilated Schemic disease or condition uear Medical resulting in death) Due to (or as a consequence of) , Examiner gronding YEARS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Diabetes Mellitus or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Month Dav Year Pregnant at time of death 1 ∐ Yes ∠ y 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 📉 No Other: 1 🗌 Yes မှ 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ieral Director: After filled in by the funer Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2010

State Registrar

DHMH 17 Rev 7/2009

LEMORIAZ

UNION

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#12perFH, G905, 7/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene 2010 State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ERNEST KIRK BREEDEN 1241 AM JUL 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOWARD HOWARD HUSPITAL COLUMBIA COUNTY GENERAL 5. Social Security Numbe If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Year) Nov 18, 1931 215-38-9962 Days 78 Director MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic account. or items 23a or 28a-f show 10a, State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD Howard West Friendship 1 🗌 Yes 2 🌠 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2820 Pfefferkorn Rd. 21794 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. 1955-56 Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Gas & Electric **Baltimore Gas & Electric** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **Ernest Luther Breeden** Helen Kirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2820 Pfefferkorn Rd. West Friendship, MD 21794 Eleanor Breeden spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nerd : 1-12-10 ICIUCOUL Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 2.1 Signa re of Furieral 23a. Part 1. Sater the dicease, or complicatione hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician, PNEVMONIA ASPIKAT70N DAY Medical resulting in death) Examiner ISCHEMIC CARDIOM YEAR) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year the been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has build director, page 2 sl autopsy performe 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA hours after death.

neral Director: After this
d filled in by the funeral d After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗆 Yes 2 🗆 No Accident Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title D63242 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 S. DACA STREET 2ND FLOOR BALTIMINE MD 21201 SHAM 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 8.9 per fh g905 7-16-10 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Raymond Physician/ Month Year 2010 Ellsworth 17.25 M Bass, Jr. JULY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NIA SINAI HOSPITAL BALTIMORE OF BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 217.84.8199 Hours Min. 11-15-1972 Country) Director MD. Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Pikesviile Baltimore MD 1 🗌 Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21208 Court Gear US.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mental Health ounselor RAYMOND 12th grade Vear Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ saymond Inda bhnsor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raren Michele Pikesville MD 21208 Geary Gure Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
LAKEVIEW CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD 17 2010 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Vaugan C. Greene Funeral Services 22. Name and Address of Facility Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lead failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ANOXIC BRAIN disease or condition resulting in death) DAYS INJURY Medical Due to (or as a consequence of): Examiner DAYS MYOCARDIAL INFARCTION Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year n signed by the a 1 Yes 2 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 RENAL PAILURE 2 No 3 □ Probably 4 □ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Arshbreet Kawn MBBS RES-000 JULY 20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAUR SINAL 405PITAL BALTIMORE OF 31. Date filed (Month, Day 32. Registrar's Signature State 142010 Registrar

DHMH 17 Rev 7/2009

as

KNOWN

Patient

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July Physician/ 2010 11:05 AM Boxwell Lee Bruce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cranberry Cottage VI Glen Burnie Anne Arundel 5. Social Security Number **9000** 579-44-**9400** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) 04/15/1935 1 🔀 M 2 🗆 F Months Davs Hours Min. Washington, Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland trent of Health and Mental Hygiene. It ant if flem 22 is marked on the than "natural", or items 23a or 28a-f sho iury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1853 Sharwood Place 21114 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 K Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Transportation School Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Nick Boxwell Evelvn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Boxwell / Daughter 1853 Sharwood Place, Crofton MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 07/13/2010 Hanover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Pair Medical Due to (or as cons uenc of Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) detached 9 Unknown ģ completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ■ Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 HNo Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 24 hours after death. Funeral Director: A ☐ Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Certifying Purse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

□ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Thyas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

	•	State Registrar		(Certifica	te of Dea	th		Reg. No.	UIU	210	010
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying I	Physician: To the best of my aminer: On the basis of exan	knowledge, d	leath occured a	at the time, date	e and place, a	nd due to the ca	use(s) and r	manner as sta	ted.	nner stated
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		30. Name and address of person w	ho completed cause of deat	h (Item 23a) (T	vpe. Print)	D 408	270		Jue	112, 2	-010	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center **Annapolis** 5. Social Security Number If Under 1 Year | If Under 24 Hrs g. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth Funeral Months Davs Hours Min. OCT 21. 1959 50 Mary Land 213-76-4812 Director Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10d. Inside City Limits 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 💢 No Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21629 USA 10830 Greensboro Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 - Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fence Installer Fencing Be or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stanley Bloom Judith Α. Gomoljak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1948 Annapolis, MD 21404 Stanley Bloom, father 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2X Cremation 3 Removal from State Metro Crematory, Inc. 07/10/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road 21228 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and De h shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated second Examine Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending newsing Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 1 Yes 2 No 1 Yes 2 Wood director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 DAR. Other: 1 Tyes 1 Prinpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After thi completed filled in by the funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury **W**Natural 5 Pending work 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) e and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are piple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Arthur Herbert Becker, Sr. July 2010 11:10AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Gilchrist Hospice Center Towson 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth If Under 24 9. Birthplace (State or Foreign **Funeral** July 15, 1914 1 **№** M 2 □ F Months Days Hours 215-07-7517 Baltimore, MD **Director** 95 Usual Residence of Decedent 28a-f show 10b County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore County Cockeysville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a 21030 12170 Falls Road United States items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give W W Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. and Mental Hygiene. is marked other than "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 🔀 Widowed 4 🗀 Divorced W.W.II Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Wholesale & Retail Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Business N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Henry Becker Katherine Pauline Messner 19a. Informant's Name/Relationship (Type, Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Herbert Becker, Jr. Ph. D. 31 Wally Court Timonium, 21093 Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Tent of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State (Baltimore Co.) 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens Timonium. Marvland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A.

Primonium Maryland 21893-2215 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 23a. Purv . E ter the distance, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shorts, other it fair the e. List only one cruyer on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) transit. that initiated events Due to (or as a consequence of): ng physician at as the burial-t resulting in death) Last Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 page 2 2 🗆 No 1 Tyes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident 8:30A.M 1 Tes tall Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1270 Falls Rel Cockerping inf 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hone Cockerpule in Dail Medical

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Division within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

29a. Certifier (Check

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

F2 22

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene 0 10 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lemon Lee Barnes Jr. July 10 pay 2010 3:47 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 64 1 🛛 M 2 🗆 F Months Days 0877777 1945 NC Director 10b. County Pitt permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director Greenville 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 400 A Deck Street 23824 12. Was Decedent Ever in U.S.

Armed Forces?

1 □ Xyes 2 □ No NAVY
If Yes, Give 1 9 6 3 - 71

Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1,4 or 5+) Government Worker Department of Commerce Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Bell Johnson Lemon Lee Barnes Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1003 Ashleigh Station Court, Bowie, MD 20721 19a. Informant's Name/Relationship (Type, Print) Andre N. Barnes, Sr./ Son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Final Journey Crem. 1 Burial 2 Cremation 3 Removal from State 7/13/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Marshall . Signature of Funeral Service Lice ^{22. NaMary Tanto Cremation Services}
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Danito (unas a cursequence of) Exami the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown detached within 24 hours after death.

To the Funeral Director: After this certificate has been signed by templeted filled in by the funeral director, page 2 should be detact Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖵 🗚 6 မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner de ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060100

State

Defin lass

Jun En

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registal Signature

31

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21880 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2ดีปึก Tuly FELICIANO JIMENEZ CRISPIN 6:00pM Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner <u>Burtonsville</u> Sanctuary At Holy Cross 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 € M 2 □ F Min. Months Days Hours (Month, Day, Year) Country 50 Director Guatemala anuary 576-27-1635 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location death with the Maryland Director Y Yes 2 ☐ No Upper Marlboro Maryland Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Guatemala 9609 Miadow Lark 20772 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Was Deceuent ____ Armed Forces? ¹ ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1√2 Yes 2□No Specify: Guatemalan Specify: WHite If Yes, Give Year or Dates. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Car Dealer Degree Car Shop traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alejandro Jimenez Rosaura de Jimenez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9609 Miadow Lark Ave Upper Marlboro, P G. 20772 Irma Aide Guerra Jimenez 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. Burial 2 Cremation 3 Removal from State 7/17/10 Palin Estdo:Escuintla 4 ☐ Donation 5 ☐ Other (Specify) alin de Escuintla 22. Name and Address of Facility Santa Cruz Funerales Latinos, Inc Signature of Funeral Service 600 Kennedy St, NW:Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death HEPATIC Immediate Cause (Final ENCEPHALOPATHY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner STACIE END Enquired to the proditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atten completed filled in by the funeral director, page 2 should be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death Unknown P.O. Pact II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MELLITUR 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? ESO PHAGTERL 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 No 1 Yes Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) all MI MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ASNEEM

2835

mi

SUITE 203

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien | |

	, F	or State Registrar			aryland /		ent of He ate of D		R	eg. No.	0 2	21881
Physician /Medical	1. De	cedent's Name	e (First, Middle, La	ne Clar	K J	V.			2. Date of Dea Month	Day 2	200	3. Time of Death 9:46 P M
Examiner Funeral Director	M	acility Name (I	Medic	e street and number) CLU Sex 7. Age	e (In yrs. last		der 1 Year	ocation of Death 101 C If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		9. Birthpl	lace (State or Foreign try) MD
pu &	Usual	Residence of	Decedent 10b. County		10c City To	own or Location					110	0d. Inside City Limits
the Marylan 28a-f ehow notified at	104.	MD	rob. Gominy		•	imore						1 X Yes 2 ☐ No
deeth with the Maryland me 23e or 28a-1 ehow frivat be notifiled at neral Director		Street and Nu	mber Wilhelm	Street			Zip Code 21223		1	l0g. Citizen of	What Coun	try?
efter or free	11		ied 2 Married	12. Was Decedent Barmed Forces? 1 Yes 2 N If Yes, Give Year or Dates:				panic Origin? (Spec Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Ra Bla Speci	ace - Americ ack, White, o ify: B1	
re, Maryland 21215-0036 s 1 end 2 should be filled within 72 hours effer f Heelth end Mental Hyglene. Item 27 is marked other then "naturel", or its other traumetic event, the Medical Examina To Be Completed by Fur	Ele	(Specomentary/Seco	15. Decedent's E eify only highest gra Indary (0-12)	ducation ade completed) College (1-4or 5		6a. Decedent's l (Give kind or life. OO NO	Isual Occupati work done dui T use retired)	on ring most of working	g	16b. Kind of I	Business/Inc	_{dustry} na
laryland 212' 2 should be filed within end Mental Hyglene. Is marked other then aumetic event, the M TO Be Comp			(First, Middle, Last T. Cla					8. Mother's Name Takeyia			ime)	
end 2 she selth end n 27 te mu	Т	akeyi	ame/Relationship (a Brown	Type, Print) -Mother		2116	Vilhel	Mumber or Rural m Stree	t Balt	to, MI	212	23
Baltimore, Ma permit. Pegas 1 end 2 Depertment of Heelih e Important: If Item 27 is eny injury or other tra	1			Removal from State	ceme	of Disposition (tery, crematory	or other place)	7-8-	2010	20c. Location Balto	, MD	wn, State
Balt permit. Depertit mport mport eny foil		(A)	M. Ob- 1.	plications that caused one cause on each lin		110		North A		Balto		21202
68760, ilicate be executed g physicien end as the burdel-transit edical Examiner	Sequif any cause Cause that in	ediate Cause isse or condition in death) entially list co. , leading to in a Disease or nitiated events ing in death) I	nditions, imediate dying	b. Due to (or as a Due to (or a) D	a consequenc	ee of):	natu	vity				Onset and Death
VISION Of VITAI RECORDS, P.O. BOX 6 Attending Physician: The law requires that the death certific or death. ector: After this certificate has been signed by the eltending py the funeral director, page 2 should be deteched for use as ification; To Be Completed by Physician/Met	23b.	MALE: Was deceden in the past 12 1 Yes 2 [9 Unknown	months? ☐No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		c pregnancy (specify)				ate of delive	ry Day Year
rdS, P quires that in signed b uid be dett	Part II	. Other signif	icant conditions	contributing to death bu	ıt not resulting	g in the underlyi	g cause given	in Part I.	23e. Did to 1 ☐ Y		ntribute to th	e cause of death? ably 4 DUnknown
DIVISION Of VITAI RECORDS, or Attending Physician: The law requires that death. Director: After this certificete has been signed in by the funeral director, page 2 should be ertification; To Be Completed by	_		-				-		24a. Was a autops perfor	in 24b sy med? 2 No	Were autoprior to condeath?	psy findings available impletion of cause of
Vital Fictor: The certificate rector, pag	8)	caminer?	red to medical	Hospital:			Other	26. Place of Death				
DIVISION Of VITAL He hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate hompletely filled in by the funeral director, page Medical Certification; To Be Com	27. M	☐ Yes 2 anner of Deat Natural ☐ Accident		28a. Date of Injur (Month, Day	y 28b	Outpatient 3 Time of Injury M	28c. Injury a Work?	4 Nursing non	ie 5 ☐ Resid 8d. Describe h			/)
DIVISION C To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification;	3	Suicide Homicide	6 Could not be determined	e 28e. Place of Injubuilding, etc		farm, street, fac	tory, office	2	8f. Location (S City or Tow	treet and Num n, State)	nber or Rura	l Route Number,
the Hospitutin 24 hours of the Funeral mpletely fille		Certifier (Check only one)	1 Certifying Pt 2 Medical Exam	nysician: To the best on niner: On the basis of and manner sta	examination a	ge, death occur and/or investiga	ed at the time, ion, in my opin	, date and place, a sion, death occurre	nd due to the c d at the time, o	ause(s) and n late and place	a and due to	atod. the cause(s)
To t To the com	29b. S	Signature and	title of certifier	al N.O.			29c. License r	61078		Ped. Date sign	RED (Month, I	Day, Year)
21	30. N	ADra	ess of person who who	completed cause of de	ath (Item 23a	a) (Type, Print) H. Rul	Place	Caltin	we, 1	MD :	2120	2
State Registrar	31. D	ate filed (Mon	th, Day, Year)	32. Registra	r's Signature	and I		,	•			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 2 1882 Certificate of Death Reg. No.
	Physicia Media		1. Decedent's Name (First, Middle, Last) Wesley Ronald Chalk, Sr. 2. Date of Death July 10, 2010 6:30 A M
	Examir	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		215-70-5146 1X M 2 F 54 Yrs. Months Days Hours Min. AUG 2, 1955 Country Country Maryland Usual Residence of Decedent
	land f show d at	ģ	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	e Mary r 28a-i notifie	Director	MD N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street and Number 10f. Zip Code 10e. Street 20e.
	s 23a o	Funeral	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA
36	e filed within 72 hours after death with the Maryland Ital Hygiene. 9d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ğ	11. Marital Status 1
2-00	hours 'natura dical E	olete	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
21215-0036	thin 72 ene. than '	Completed	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired)
d 2	be filed wi ental Hygic ked other ic event, ti	Be	12 Roofer Roofing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
ylar	buld be fi d Mental marked matic ev	은	William Nimrod Chalk Augusta Adolphina Burton
Maryland	d 2 should be file aith and Mental I I 27 is marked o er traumatic eve	79	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	of Heal		Tammy L. Elliot, daughter 6003 Mannington Avenue Baltimore, MD 21206 20a. Method of Disposition (Name of Date Date Date Date Date Date Date Date
Baltimore,	Page nent int: I		20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 20c. Location - City or Town, State Baltimore, MD
Ball	permit. Page Department Important: I any injury o	d	21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Maryland 21228
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between
	Ph_sician/ Medical	4 1	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):
-	Examiner		Sequentially list conditions, b.
	sit sd	Examiner	the description of the control of th
	xecute n and al-tran		resulting in death) Last C. Due to (or as a consequence of):
09	cate be executed physician and s the burial-transit	edical	d
687	ertifica ding pl		F FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnancy
Box	law requires that the death certificate be executed ras been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1
s, P.O	requires that the de been signed by the should be detached	<u>ک</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
örd	w requisite been 2 should	Completed	24a. Was an 24b. Were autopsy findings available
ž	The ate h	Sol	autopsy prior to completion of cause of performed? death? 1 □ Yes 2 □ No
Ita	sician; certific irector,	m ,	25. Was case referred to medical examiner? 1
<u></u>	ig Phy ter this neral d	te: To	27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
on	tendin Jeath. Ior. Aff the fur	Certificate:	2 Accident Investigation M 1 Yes 2 No
Division of Vital Records,	al or Ai s after il Direc id in by		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	Not Not Not Not Not Not Not Not Not Not		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		-	39. Name and address of person who completed cause of death (Item 23a) (Type, Print)
			Kelperea Sittula 555 West Towsontown Bud Towson MD 21204
	State Registra	~	31. Date filed (Month, Day, Year) JUL 14 2010 32. Figistrar's Signature July 14 2010 Since J. January

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and Mental ertificate of Death	Hygiene 010 21883			
	Physici /Medi		C. VIIIO POINCE LIGHT AREAR	DAVIS 2. Date of June				
	Examir		4a. Facility Name (If not institution, give street and number) 1499 EAST ST. APT ID	4b. City, Town, or Location of Death FRED ERICK	4c. County of Death FREDERICK			
h	Funeral Director		5. Social Security Number 215-26-8590 6. Sex 1 M 2 F F 80 Yrs. Usual Residence of Decedent	Months Days Hours Min (Mont	of Birth Day, Year) 9. Birthplace (State or Foreign Country) M.D.,			
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits 1/∐Yes 2 □ No			
:	h with the	al Director		10f. Zip Code 2170/	10g. Citizen of What Country?			
920	be lied within 72 hours after death with the Maryland tall Hygiene. tall Hygiene. d other than "natural", or items 23a or 28a-f show event, I're Medical Examinar must be neathed at	by Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?, 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:	or No- 14. Race - American Indian, Black, White, etc. Specify: BLACK			
Maryland 21215-0036	vithin 72 hou ene. than "natura e Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) LE GIVER	16b. Kind of Business/Industry HOM E FOR AGED			
land 2	ed d d	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi	iddle, Maiden Surname)			
	s 1 and 2 should be if Health and Menta item 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Type. Print) 19b. Mai 19c (DAV) 1770	ling Address (Street and Number or Rural Route N CARRIAGE WAY FR	lumber, City or Town, State, Zip Code) EOGRICIC IND 21702			
altimore,	rage nat: if iny or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition Crematery, createry, ematory or other place)	200. Location - City or Town, State 2010 FREDERICK MD, ROLLINS FUN HOME				
Ba	Departing Departing Importation and Injurial		Thursday beauting	10 NEST SOUTH ST FREE	ERICH ME CITOI			
	hysician /Medical	9 9	23a. Part 1. Enter the disease, or complications that caused the death. Do not ensure shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	nter the mode of dying, such as cardiac or respirate	ory arrest, Approximate Interval Between Onset and Death			
· ·	xaminer	iner	Sequentially list conditions					
/60,0%	sician and burial-trans	al Examiner	that initiated events c. resulting in death) Last C. Due to (or as a consequence of):):				
X 68	atter for u	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (<i>specify</i>)	23d. Date of delivery Month Day Year			
ecords, P.	en signed by				Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
Of VITAL RECORDS, P.O. Bo	certificate has bee	Completed by		1 DY				
OT VII	After this certi funeral directo	: To Be						
Or Attending Phy	within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification: To	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	Work? M 1 □ Yes 2 □ No treet, factory, office 28f. Locati	ion (Street and Number or Rural Route Number, r Town, State)			
L Hospital	n 24 hours le Funeral bletely filled	Medical Ce		th occurred at the time, date and place, and due to investigation, in my opinion, death occurred at the t	o the cause(s) and manner as stated, time, date and place, and due to the cause(s)			
To #	To th	Me	29b. Signature and title of certifier	29c. License number D 60417	29d. Date signed (Month, Day, Year) 7-14-2-010			
	3		30. Name and address of person who completed cause of death (Item 23a) (Type Hemen Such 256 Thomas T		evice MD 2170)			
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (# not institution, give street and number N.W. Seasons Hospice 4b. City, Town, or Location of Death Randlestown Examiner Baltimore If Under 1 Year If Under 24 Hrs. Funeral 5. Social Security Number 218-28-3035 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) MD 1 X M 2 - F Months Days Hours Min. 5/Month 33 Director Usual Residence of Decedent 28a-f show 10a. State 10b County Baltimore 10c. City, Town or Location Lochean Examiner must be notified at Director 10d. Inside City Limits 1 🗆 Yes 2 🗖 No 10f, Zip Code 2 I 2 0 7 0 10e. Street and Number 3601 Cedar Dr. 10g. Citizen of What Country? Funeral "natural", or items 23a filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black White etc. A ITICan ecify: American Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 1 ☐ Yes 2 No Specify. 3 Divorced Specify: Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me P&G Mechnic retired) Elementary/Sezonday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Eugene Murdock 18. Mother's Name (First, Middle, Maiden Surname) Cassie Smith-Dorsey , 19a. Informant's Name/Relationship (Type, Print) Marchelle Simpson/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 Cedar Dr., Lochean, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 $\begin{tabular}{|c|c|c|c|c|}\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Cremation & 3 & \square & Removal from State \\\hline A & Crematical & 3 & \square & Removal from State \\\hline A & Crematical & 3 & \square & Removal from State \\\hline A & Crematical & 3 & \square & Removal from State \\\hline A & Crematical & 3 & \square & Removal from State \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Removal \\\hline A & Crematical & 3 & \square & Removal & 3 & \square & Remova$ Bayview comatory of other place) 7/19/10 Balt.,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral ice License 22 Name and Address of Facility Hari P. Close F.Svs,FA 5126 Belair Rd, Balt.,MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) puman Medical Diff to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be exec Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 \square Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work Investigation 1 Tyes 2 🗌 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29d. Date

DHMH 17 Rev 7/2009

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Registrar

State

ne and address of person who

mpleted cause of death (Item 23a) (Type, Print)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician Well-dead Committed Commit			For State OF N State Registrar	iai yiai iu / L	Cert	ificate of D	eath		Reg. No.	2010	21885)
MILLIA COLL LANGE AND A COLL COLL COLL COLL COLL COLL COLL CO	Physicia	an/	1. Decedent's Name (First, Middle, Last)	'				2. Date of De Month	ath	Year	3. Time of Death	
TOTAL DOCUMENT OF THE PROPERTY	Medi	cal		Frazier		4b City Town or l	Location of Death		6	2010	1:20 P ^M	\dashv
Director 23 - 2 - 2310 124 to 12	Examii ——	ner			Trappe	Location of Boats						
Trappe Trappe			213-24-2310 1⅓M 2□F					8. Date of Bir (Month, Da 08/12	th y, Year) /1928	9. Birth Court Mary	place (State or Foreign try) Land	
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RODERT FIRST 21CT / SOIN Banal 2 Grandston at Planch 2 Date	death v items ier mu	Fun	11 Marital Status 12, Was Deceden	Ever in U.S.	13. W		spanic Origin? (Sp	ecify Yes or No- Rican, etc.)		14. Race - Americ		٦
RODERT FIRST 21CT / SOIN Banal 2 Grandston at Planch 2 Date	336 after all, or Examir	d by	1 X Never Married 2 Married 1 X Yes 2 If Yes, Give	No	1					Coocifu -		
RODERT FIRST 21CT / SOIN Banal 2 Grandston at Planch 2 Date	5-00	plete	15. Decedent's Education	16a.	(Give ki	nd of work done du	ution uring most of work	king	16b. Ki	nd of Business In	dustry	
RODERT FIRST 21CT / SOIN Banal 2 Grandston at Planch 2 Date	ithin 72 ene. r than	Com	Elementary/Seconday (0-12) College (1-4 or	5+)			er		Au	tomotive	9	
RODERT FIRST 21CT / SOIN Banal 2 Grandston at Planch 2 Date	nd 2	Be		L				ne (First, Middle,		_		٦
RODERT FIRST 21CT / SOIN Banal 2 Grandston at Planch 2 Date	ylal											\dashv
Bautal 2 Commalon 3 Removal from State Anatomy of its Registry 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Hanover, Maryland 07/07/2010 Ha				1	-	,					Codej	
23a Part 1. Enter the disease, or coefficients that caused the death. Do not enter the mode of dying, such as cardials or respiratory errest, shock or hear failure. List only one cause on each line. Approximate and the death of the death	or Head of Head if item		20a. Method of Disposition	20b. Place o	of Dispos	tion (Name of	e)	Date	20c. Lo	ocation - City or To		٦
23a Part 1. Enter the disease, or coefficients that caused the death. Do not enter the mode of dying, such as cardials or respiratory errest, shock or hear failure. List only one cause on each line. Approximate and the death of the death	tim it. Page rtment rtant: I		4 X Donation 5 ☐ Other (Specify)	Anaton	y Gif	ts Registr						\dashv
Sequentially list conditions, cause finding cause (brief underlying cause consequence of): Due to (or as a consequence of):	Ba perm Depa Impo any ii		21. Signature of Funeral Service Licensee									
Sequentially list conditions. Sequentially list conditions.	Medical		shock, or heart failure. List only one cause on each line limmediate Cause (Final disease or condition	MOUS	CEL						Approximate Interval Between Onset and Death	S
State Stat	Examiner		Sequentially list conditions, b.	aracan asabin acas								_
State Stat	ted nsit	m ju	cause. Enter Underlying Cause (Disease or linjury	oryo-	1							
FEMALE: 23c. If yes, outcome of pregnancy 1	be execur sician and burial-tra	ical Exa	that initiated events resulting in death) Last C. Due to (or a d.	s a consequence	of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			IF FFMALE:									
Whichard Moskews Mis D16609 JULY 8 2010 30 Name and address of person who completed cause of death (Item 28a) (Type, Print) MICHAEL A. WOSLEWICZ MS 830 CHESA PEAKE DRIVE; MARY LAND 216 (Item 28a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Projector's Signature	Box 6 e death cert the attendii	ysician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 1 Yes 2 No 23c. If yes, outcome 1 Live Birtl Pregnant 1 Yes 2 No 1 Yes 20 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N	at time of death			У		100.1			
Whichard Moskews Mis D16609 JULY 8 2010 30 Name and address of person who completed cause of death (Item 28a) (Type, Print) MICHAEL A. WOSLEWICZ MS 830 CHESA PEAKE DRIVE; MARY LAND 216 (Item 28a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Projector's Signature	IS, P.O.		Part II. Other significant conditions contributing to death	but not resulting FALLU	in the un	derlying cause give	en in Part I.					า
Whichard Moskews Mis D16609 JULY 8 2010 30 Name and address of person who completed cause of death (Item 28a) (Type, Print) MICHAEL A. WOSLEWICZ MS 830 CHESA PEAKE DRIVE; MARY LAND 216 (Item 28a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Projector's Signature	Record The låw requate has been	Somplet						auto	DSV	prior to co	impletion of cause of	
Whichard Moskews Mis D16609 JULY 8 2010 30 Name and address of person who completed cause of death (Item 28a) (Type, Print) MICHAEL A. WOSLEWICZ MS 830 CHESA PEAKE DRIVE; MARY LAND 216 (Item 28a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Projector's Signature	ician: certific ector,	Be	examiner?			Othe	ır.					=
Whichard Moskews Mis D16609 JULY 8 2010 30 Name and address of person who completed cause of death (Item 28a) (Type, Print) MICHAEL A. WOSLEWICZ MS 830 CHESA PEAKE DRIVE; MARY LAND 216 (Item 28a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Projector's Signature	of Vi		27. Manner of Death 28a. Date of in	jury 28b.	Time of	3 LJ DOA J	4 □ Nursing F at				<u>'y)</u>	_
Whichard Moskews Mis D16609 JULY 8 2010 30 Name and address of person who completed cause of death (Item 28a) (Type, Print) MICHAEL A. WOSLEWICZ MS 830 CHESA PEAKE DRIVE; MARY LAND 216 (Item 28a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Projector's Signature	ion (eath. or: After the fun	ificat	2 Accident Investigation			M 1 🗆						
Whichard Moskews Mis D16609 JULY 8 2010 30 Name and address of person who completed cause of death (Item 28a) (Type, Print) MICHAEL A. WOSLEWICZ MS 830 CHESA PEAKE DRIVE; MARY LAND 216 (Item 28a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Projector's Signature	Divis		4 Hamisida determined 286, Place of I		arm, stre	et, factory, office					al Route Number,	
Whichard Moskews Mis D16609 JULY 8 2010 30 Name and address of person who completed cause of death (Item 28a) (Type, Print) MICHAEL A. WOSLEWICZ MS 830 CHESA PEAKE DRIVE; MARY LAND 216 (Item 28a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Projector's Signature	ne Hospitt n 24 hours ne Funera	Medica	(Check 2 Medical Examiner: On the basis o	examination and/o	or investi	gation, in my opinio	n, death occurred	at the time, date	and place	, and due to the ca	ause(s) and manner state	ed.
or: Date med (months 1-14), 1947	Voithi Voithi Com		29b. Signature and title of certifier. Michaela. Mossews	MD		29c. License	number 609		29d. Dat	te signed (Month, 4 , 8 , 2	Day, Year)	
or: Date med (months 1-14), 1947			30. Name and address of person who completed cause of MICHAEL A. WOSILEW III	30, Name and address of person who completed cause of death (Item 28a) (Type, Print) MICHAEL A MOSILEWICZ MD 830 CHESAPERICE DRIVE IM APULAND 21613								
Registrar 30L 14 2010 Server S. Sould					S	ake						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 = State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 11, 2010 Year Physician/ JULY RUTH E. FEHRMANN 11:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE STELLA MARIS NURSING HOME TIMONIUM 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7/18/1915 1 □ M 2 □X MARYLAND 219-22-3556 94 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ☐ Yes 2X No BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a o Examiner must be Funeral 10883 YORK ROAD 21030 USA permit. Page 1 and 2 should be filed within 72 hours after death bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "nature"... 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Yes, Give 1 ☐ Yes 2 X No Specify. Specify: 3X Widowed 4 ☐ Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BENDIX ASSEMBLY LINE WORK 9TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HERMAN STAHLER DOROTHY WILKERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1915 PUTTY HILL AVENUE BALTIMORE, MD JANET M. FORD/DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of DULANEY VALLEY MEM. 1 X Burial 2 Cremation 3 Removal from State 7/16/2010 COCKEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MO0217 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Lung Proise shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) **Medical** Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death I signed by the Part II. O er gnifigant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown is certificate has been sidirector, page 2 should b Lilera 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) **Division of Vital** Be Was case referred to medical examiner? Other: 4 dursing Home 5 Residence 6 Other (Specify) 2 00 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 24 hours after death.
Funeral Director: After this eted filled in by the funeral dir 28a, Date of injury 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and JULY 12, 2010

Registrar
DHMH 17 Rev 7/2009

State

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, M.D.

31. Date filed (Month, Day, Year) ~

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 | 0 Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE OF NORTHWEST HOSPITA RANDALLSTOWN BALTIMORE 9. Birthplace (State or Foreign Country) RUSSIA Funeral Social Security Number 6. Sex 8. Date of Birth Hours 1 - M 2 X F 0272171944 Director 216-42-4419 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD 1 Yes 2 X No BALTIMORE RANDALLSTOWN 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3940 CARTHAGE ROAD 21133 items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 1 Yes 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🖁 No 3 Widowed 4 X Divorced Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) repartment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event any injury or other traumatic event any injury or other traumatic event any injury or other traumatic Elementary/Seconday (0-12) College (1-4 or 5+) BEAUTICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HORN FRIEDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3940 CARTHAGE ROAD, RANDALLSTOWN, MD 21133 ROBERT FELDMAN / SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date ARE TNETON CEMPTE CHIZUK AMUNO CONG. 1 X Burial 2 Cremation 3 Removal from State 07/13/2010 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause we each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate name F. ter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) 9 Unknown P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2: autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: Vatural injury 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) Date signed (Month, Day, Year) of death (Item 23a) (Typ 31. Date filed (Month, Day, Year) State Registrar

10-05192 Annie Garrett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day July 11, 2010 0950 hrs Medical Examiner Annie Garrett 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** Gilchrist Hospice Center Baltimore 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 03/10/1929 Country) N.C. 212-26-1002 1 M 2X F 81 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Pikesville Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyggene.
Innet of Health and Mental Hyggene.
Innet 1 file of 27 is marked other than "natural", or items 23a or 28a-f sho or other trannatic event, the Medical Examiner must be notified at once. Baltimore Co MDDirector 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21208 U.S.A. 3800 Old Court Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 Married 2X No 1 Yes 3 Widowed 4 X Divorced f Yes, Give Year 1 Yes 2X No specify: Specify: Black þ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life DO NOT use retired)
CETTIFIED NUTSING Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Assistant Hospital 12th Grade 17. Father's Name (First, Middle, Last) 1B.Mother's Name (First, Middle, Maiden Surname) Be Colonel Best <u>Minnie Barnes</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vergenea Wright(daughter) 31<u>04 Minna Ct.</u> Baltimore,MD 21207 20a. Method of Disposition 20b. PAppel of propertion Change of cemetery, 1 X Burial 2 Cremation 3 Removal from State SEPH BLOWN F/H ematory 07/17/10 |Baltimore,MD Donation 5 Other Specify: ²²Joseph^{dre}h. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licensee PA 21217 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Pneumonia complicating subdural hemorrhage Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED

Records, P.O. Box 68760

The law requires that the death certificate be executed After this certificate has been the Hospital or Attending Physician: Division of Vital the filled in by

ğ

Completed

Be

Certification: To

Medical

IF FEMALE:	23c. If yes, outcome of preg	nancy			23d. Date	of delivery	
23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal deat	h 3 Ectopic	oregnancy	Month	Day	Year
past 12 months:	4 Pregnant at time of de	eath 5 Other (Sp	pecify)		1		
1 Yes 2 No 9 Unknown	9 Unknown	o Other to					
Part II. Other significant conditions	contributing to death but not r	esulting in the underlying	ng cause given in Part	I. 23e. Did to	bacco use con	tribute to the ca	ause of death?
Hypertensive cardiovascu	ılar disease			1 Yes	2 🗸 No	3 Probably	4 Unknown
				24a. Was	1		findings available
				autop	med?	prior to comple death?	etion of cause of
				1 ✓ Yes		1 Yes	2 No
25. Was case referred to medical			26.Place of Death (0	check only one)			
examiner? 1 Yes 2 No	lospital: 1 🗸 Inpatient 2	ER/Outpatient 3	DOA Other	Nursing Home 5	Residence 6	Other:	
27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe l		ırred	
1 Natural 5 Pending	Jun 15, 2010	0000 hrs	1 Yes 2 🗸	Probable fal	ŀ		
2 🗸 Accident Investigation			- tr 1 11 12 13 13 13 13 13	000 1			
3 Suicide 6 Could not I		ome, rarm, street, facto	ry, office building, etc.	or Town, S		iber of Rural Ro	oute Number, City
4 Homicide determined	(Specify) Assisted L	iving Facility		3800 Old Cou		esville, MD	

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

OCME 2006

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

July 12, 2010

30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D.

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (M strar's Signature

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

Stephen 10-04851 Unk Unk	1- For State Certificate	nt of Health and Mental Hygiene	2010 21889			
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) Stephen Graham	Reg. No. 3. Time of Death Day Year 1400 hrs				
)	4a. Facility Name (if not institution, give street and number) 2113 West Mulberry Street	4b. City, Town, or Location of Death Baltimore	4c. County of Death			
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 15 1 1 1 1 1 1 1 1	ay) If Under 1 Year If Under 24Hrs. 8. Date of 6 Months Days Hours Min. 12/2	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MA			
d d sany	Usual Residence of Decedent 10a State	Location No re	10d. Inside City Limits 1 X Yes 2 No			
the Marylanc a or 28a-f sh tiffed at onc	10e Steet and Number 2113 W. Mulberry St.	10f, Zip Code 21223	10g. Citizen of What Country? USA			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1	3. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No specify:	No- 14. Race - American Indian, Black, A Miricelan American Specify.			
5-0036 ed within 72 hours. itygiene. other than "natur: the Medical Exami Completed b	Elementary/Secondary (0-12) College (1-4 or 5+)	cedent's Usual Dccupation (Give kind of work done ing most of working life. DO NOT use retired) Computer Operator	16b. Kind of Business/Industry US Treasury			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Stanley E. Graham,Sr.	18.Mother's Name (First, Middle Doris Brown				
MD 21 d 2 should dth and Me lith and Me an 27 is ma	Cairra R. Germain/Daughter 75	Mailing Address (Street and Number or Rural Route N Austin St., Hyde Park, MA	02136			
Baltimore, permit. Pages 1 an Department of Hea Important: If ite nijury or other tr.	1 Burial 2 A Cremation 3 Removal from State crematory 4 Donation 5 Other Specify:	Disposition (Name of cemetery, or other place) i.ew Crematory Date 7/14/10	20c. Location - City or Town, State Balt.,MD			
	21. Signature of Funeral Secrete Licensee 22. Name and Address of Facility Hari P. Close F. Svs 5126 Belair Rd, Balt., MD 21206					
Physician /Medi⊏al Examiner	23a. Part'I. Enter the disease, or complications that caused the death. Do not entire failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cause (or as a consequence of):	nter the mode of dying, such as cardiac or respiratory a	Approximate Interval Between Onset and Death			
ıer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
Insit	(Disease or injury that initiated events resulting in death) Last		1			
760, crate be executed physician and the burial - transit	X UNPENDED — AMENDED 7, per ME g9	05 7/29/10 TT				
OX 68' sath certification or use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year			
P.O. By ss that the de gned by the e detached i	Part II. Other significant conditions contributing to death but not resulting in		tobacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown			
Division of Vital Records, P.O tal or Attending Physician: The law requires that tar after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacertification: To Be Completed by B		per	24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No			
Vital Rec ysician: The l his certificate l director, page	25. Was case referred to medical examiner? 1 Ves 2 No. Hospital: 1 Inpatient 2 ER/Outpa	26.Place of Death (Check only one)	Residence 6 ✓ Other: Scene			
on of Vinding Physith. After this efuneral di	1 Yes 2 No		e how injury occurred			
Division o spital or Attending tours after death. The meral Director: After filled in by the tune Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, (Specify)		(Street and Number or Rural Route Number, City State)			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	use(s) and manner as stated. e and place, and due to the cause(s)					
3, N	29b. Signature and title of certifier Oute 1 Oute 1	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) June 29, 2010			
Oth	Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 21201				
State Registrar	31. Date filed (Month, Day Year) Sense 32. Registrar's Signature of Si					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 20 1 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Dav 2010 **Physician** July 8, 11:45 AM William Richard Green /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson 7908 Sherwood Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar. 1, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex 1 X M 2 ☐ F **Funeral** 1934 Kentúcky 76 405-36-5455 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show notified at 1 ☐ Yes 2 ☐ No Director Towson Baltimore 28a-f MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r USA 21204 7908 Sherwood Avenue Funeral death v 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Iten 1 ☐ Never Married 2 X Married white 1 ☐ Yes 2 🔀 No Specify Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Medical Ophthalmic Pathologist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nina Margaret Housman Rav Vernie Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar important: if item 27 is any Injury or other trauonce. 7908 Sherwood Avenue; Towson, MD 21204 / wife Janet J. Green 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Ofemation 3 Removal from State Burlington, KY 4 □ Donation 5 □ Othe (Specify) Burlington Cemetery 7/19/10 22. Name and Address of Facility 1050 York Road 21. Signature of Funeral Syrvice Livens Towson, MD 21204 Ruck Towson Funeral Home, Inc. a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) - END STAGE) CARDIOMYOPATHY Due to (or as a consequence of): YEARS **Physician** COEXISTING /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Licease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month 4☐Pregnant at time of death 9☐Unknown in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by MMUNE THROMBOCYTOPENIC 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an perfor 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of 28c. Injury at Work? Injury 1 Natural ∠ Ascident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

The discrete physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

29b. Signature and titl

30. Name and addre

31. Date filed (Month.

Registrar

DHMH 17 Rev 1/2001

of death (Item 23a) (Type, Print)

29c. License number

S RD, SUITE 200 LUTHE

29d. Date signed (Mgnth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Catherine Gill 2010 7:45 Viola July 10 \mathbf{P} M Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Howard Ellicott City Health & Rehab. Center Ellicott City If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days NOV 4, 1923 Min. 1 🗆 M 2 🕱 New Jersey 147-18-6358 86 Director Usual Residence of Decedent Show 10d. Inside City Limits or 28a-f show 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 🗌 Yes 2 🗶 No Columbia Howard MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ital Hygiene.
ed other than "natural", or items 23a or
event, the Medical Examiner must be r Funeral 21045 USA 6353 Loring Drive Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner munor or other traumatic event, the Medical Examiner munor or other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Never Married 2 Married ò 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Manufacturing Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lyons Gill Margaret Richard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21045 Columbia, Maryland 6353 Loring Drive Margaret A. McEntee, niece 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of h Important: If ite any Injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 07/12/10 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of M, Inc. 51 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Approximate Interval Between Onset and Death DEBILIT Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Ener Underlying Cause (Disease or iinjury use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day for Pregnant at time of death s been signed by the s should be detached 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No cate has k page 2 s death? 1 Yes 2 No certificate 1 Yes 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of injury 28d. Describe how injury occurred Certificate: injury

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 After this after death Director: A n 24 hours af ie Funeral Di oleted filled ir

28c. Injury at work? 1 ☐ Yes 2 ☐ No (Month, Day, Year) 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

only one 3 🗆 29b. Signature and title of certifier

29c, License number

29d. Date signed (Month, Day, Year) July 12, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Columbia, MD Kenneth N. Geh, 10840 Little Patuxent Pkwy., M.D.

State Registrar

Medical

DHMH 17 Rev 7/2009

within 2 To the I

10-05156 Leonard Leroy Green Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 21892
State of Maryland / Department of Health and Mental Hygiene

,	1- For State Certificate of Death Reg. No.	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Leonard Roy Green 2. Date of Death Month Day Year July 9, 2010 7-10-2010 3. Tim	ne of Death 49 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery	
Funeral Director	5. Social Security Number 032-20-2960 6. Sex 79 79 79 77 79 77 79 77 79 77 79 77 79 77 79 77 79 77 79 77 79 77 79 77 79 77 79 77 79 77 79 77 79 79	(State or MA
land f show any once.	MD Howard Columbia 1 K	nside City Limits Yes 2 No
death with the Maryland or items 23s or 28s-f shomust be notified at once uneral Director	10e. Street and Number 9501 Sea Shadow 10f. Zip Code 21046 USA	
~ ~ TI III	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16. Was Decedent Ever in U.S. 17. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. White 10. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Yes 2 No specify: 11. Was Decedent of Hispanic Origin? (Specify Yes or No- White, etc. 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Ind Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Decedent's Education (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. White, etc. 17. Yes 2 No specify: 18. Decedent's Usual Occupation (Give kind of work done) 19. White, etc. 19. Specify: 19. Specif	
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner: To Be Completed by F	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ College (1-4 or 5+) Psychologist Mental He	alth
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Jacob Green Sadie Superior	
MD 212. nd 2 should be saith and Menta. on 27 is marke. raumatic event	19a. Informant's Name/Relationship (Type, Print) Mary Jane McCord / Spouse 10019 Kinross Avenue, Silver Sprind	g, MD
imore, Pages 1 a nent of He ant: If ite or other ti	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Final Journey Crem. 20c. Location - City or Town, 7/10/2010 Woodbine, MD	
		1203
Physician /Medi_al Examiner		roximate Interval ween Onset and Death
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ted Insit Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
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P.O. Be sthat the degree by the detached for by the by Phy		
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tal R cian: T certific ector, p	25. Was case referred to medical examiner? 25. Place of Death (Check only one)	
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Sion c sttending death. ctor: Aft y the fun	1 Natural 5 Pending FOWND: Day, Year) FOUND: 1 Yes 2 No Subject fell down stairs	¥.
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Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be C	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	e(s)
Me is a	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Da 3 July 10, 2010	y, Year)
m√	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day, Year) 32. Rigistrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ZLIK Month 2010 SEMAR Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1009 Cedar Ridge Court Annapolis Anne Arundel 7. Age (In yrs. last birthday) 74 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Y Aug. 7 9. Birthplace (State or Foreign **Funeral** 488-28-3807 Months 1 M 2 F **Director** 1925 Missouri Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "naturo" any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Slade Avenue, #809 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Textile Artist Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ben Weinstein ပ Berger Dena 19a. Informant's Name/Relationship (Type, Print) Barbara Ellen Glik / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 Cedar Ridge Court, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Final Journey Crem. 1 Burial 2 Cremation 3 Removal from State 7/10/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD of Funeral Service License DOTOLa Marshall Maryland Cremation Services PO Box 1413, Baltimore, MD MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ UNG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death Month 5 Other (specify) Day Year been signed by the should be detached g 🗍 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 K Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performe this certificate Yes 2 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Ref 6 HUME မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1-Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of g

Registrar
DHMH 17 Rev 7/2009

State

Name and address of person w

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type,

DA NO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per inf e905 7-14-10 vt. State of Maryland 7 Department of Health and Mental Hygiene 2010 Certificate of Death

		for State Registrar	State of Ma		Certificate of D		vieritai my	Reg. No.	010	21034
Physici Med		1. Decedent's Name (First, Middle, ANNETTE	HAR.	RIS			2. Date of De	ob Ob	/ Sar	3. Time of Death 8418 AM
Exami		4a. Facility Name (if not institution, g				Location of Death	102	4c. County of Death		
Funera	-	7629 Water Oak 5. Social Security Number	. Sex 7. Age	(In yrs. last birtho	Pasader lay) If Under 1 Year	1a If Under 24 Hrs.	8. Date of Bir		Aruno	elace (State or Foreign
Directo		213-64-4625	1 □ M 2 20 F	56 Y	s. Months Days	Hours Min.	087307	1953	Mary	Yand
ind show at	٦,	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of	or Location				1	0d. Inside City Limits
Maryla 28a-f s	Director	MD Anne	Arundel	Pasade	na					1 ☐ Yes 2 🔀 No
th the	a Di	10e. Street and Number			10f. Zip Code			10g. Citizen o		itry?
eth wi	Funeral	7629 Water Oak	Point Road 12. Was Decedent E	ver in U.S.	21122 13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	U.S.A.	ace - Americ	an Indian.
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ē	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🔀 Divorced	Armed Forces? 1 Yes 2 X I If Yes, Give Year or Dates.	No	If Yes, specify Cuba 1 ☐ Yes 2 🔀 No		Rican, etc.)	Speci	lack, White,	
21215-0036 within 72 hours after giene. ier than "natural", o	Completed	15. Decedent' (Specify only highest Elementary/Seconday (0-12) 12		+) (0	lecedent's Usual Occupa Give kind of work done a fe. DO NOT use retired)	during most of work			Business Inc	·
iled wi Hygie other	Be	17. Father's Name (First, Middle, Lat	Ist)	Adı	ministratio 	18. Mother's Nan		POWer Maiden Surna		ergy
yland Id be filed Mental Hy arked oth	6	Gilbirt L	. Harr	is		Janet	Mar	ie	Chey	- Oney
e, Maryland and 2 should be filed Health and Mental Hy tem 27 is marked oth		19a. Informant's Name/Relationship Annette Jennifer We	, , ,		Mailing Address (Street a 29 Water Oa					
Baltimore, permit. Page 1 and Department of Hea Important: If Item any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Sp		cemetery,	Disposition (Name of crematory or other plac Gifts Registr		Date 2/2010	20c. Location		
Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lic	ensee		22. Name and Addres					
		23a. Part 1. Enter the disease, or c	on plications that caused	the death. Do not		•		•	VOL , IVI	Approximate
Physician Medica		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	BRA	consequence of)	Ancer	-Glio	blast	oma	_ >	Interval Between Onset and Death
Examine		Sequentially list conditions,	b. ———							
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3760 ficate be executed g physician and as the burial-transit	that initiated events resulting in death) Last Due to (or as a consequence of):									
:- 5	Medic		d							
ivision of Vital Records, P.O. Box 687 or Attending Physician: The law requires that the death certifics free death. Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as it in by the funeral director, page 2 should be detached for use as it.	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 Ectopic pregnanc 5 Other (specify)	y			Date of delive Month	ery Day Year
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ds,	ted						1 🗆	Yes 2 No	3 🗌 Prob	pably 4 🗆 Unknown
Division of Vital Records, as or Attending Physician: The law requires is after death. Indirector: After this certificate has been signed in by the funeral director, page 2 should be done by the funeral director.	Completed								b. Were autor prior to cor death? 1 \(\sum Yes\)	osy findings available mpletion of cause of
fital sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	Hospital:		Othe	ace of Death (Chec	4			
n of V ding Phys h. After this funeral di	te: To	27. Manner of Death	28a. Date of injur (Month, Day,		ne of 28c. Injury		28d. Describe)
ion tendin leath. tor: Aff the fur	Certificate:	1 Natural 5 □ Pending 2 □ Accident Investiga 3 □ Suicide 6 □ Could no	tion		M 1 🗆	Yes 2 □ No				
Divis ital or At irs after o al Direct led in by		4 Homicide determin	ed 28e. Place of Injul building, etc.	(Specify)	, street, factory, office		City or Tov	vn, State)		Route Number,
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: Al completed filled in by the fu	Medical	only one) 3 Certifying N	hysicían: To the best of r aminer: On the basis of ex lurse Practioner: To the b	amination and/or I	nvestigation, in my opinio	on, death occurred a	t the time, date a	and place, and one cause(s) and	manner as sta	use(s) and manner stated. ated.
D wit		29b. Signature and title of certifier	4. Krieg	er ne	> 29c. License	1 & 3 &		29d. Date sig	oed (Month, I	Day, Year)
		SUSAN H.	NO completed cause of de	ER, M		eknse	Hwy.	Anna	polly	MOZIYA
Sta Registi		31. Date filed (Month, Day Year)	2010 32. Registrar	's Signature	had 1		/	/	•	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 20 | 0 | 0 | Certificate of Death 1 - State Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ... Day Year 457 AM Montgomery Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore MI VETE, My 200 Maryland Medical Cto Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Hours Min. 216-44-6103 61 10-30-1948 **Director** MD Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35 N. LAKEWOOD **APT 302** 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 ☐ No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: Specify: BLACK Completed 3 ₩Widowed 4 Divorced Year or Dates. 1971-73 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEERING VA MEDICAL CENTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ JAMES W. HACK SARAH BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 628 MAIN STREET, DUNDALK, MD 21222 TANISHA_HACK/DAUGHTER Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 07/21/2010 020. Location - City or Town, State Owings Mills, MD BALTIMORE, MD Garrison Forest 4 Donation 5 Other (Specify) 07/20/2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC a. Kam 1701 LAURENS STREET, BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ erebrolascular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exe physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ģ Day Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No page 2 s this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🔀 No Hospital: Other: Certificate: To 1 🗌 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 1003041997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S Gre Vishal Bhatna ME 5+ Baltimore MO 21201 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death Physician/ 201 :30 AM Medical Name (if not institution, give str 4b. City, Town, or Location of Death 4c. County of Death Examiner ochearn tomore If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 🗆 Months Davs Hours Min. 91ont Pay, Country) MD Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director MDaltimore 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numb Funeral alals venue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. δ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working His DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other I any injury or other traumatic event, th Be ner's Name (First, Midtle, Last) 18 Mothe Name (First Middle Maiden Surname ೨ Name/Relationship (Type, Baltimore, 20b. Place of Disposition ceptetery, cremator 20a. Method of Disposition Date 20c. Location 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) or other 21. Signal re of Fun ral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ nerosc. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Divi to (or as a consection result) Exami that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death 9 Unknown signed by the and be detached to 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Records, Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 124 hours after death. e Funeral Director; After this certificate has performed? 1 ☐ Yes 2 ☐ No Yes 2 1 N 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, Be Hospital: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? _1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending Investigation Accident completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 [only one) 29b. Signature and title of cert 29c, License number 29d. Date signed (Month, Day, Year) D00433 12010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TE ZUZ 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 70/0 0248 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel **1236 Youngs Farm Road** Annapolis If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 M 2 F Months Hours California 1965 Director 45 555-65-4691 JAN 1 Jsual Residence of Deceden 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 1 Tes 2 XNo MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 USA 1236 Youngs Farm Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Social Work icensed Social Worker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harkins Lydia Pendergraft John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Annapolis, MD Bryan M. Enders, (S.O., husband) 1236 Youngs Farm Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 07/12/10 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Signature of Funeral Service Licensee George MacNabb CM 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No -Month Year Day 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tyes 2 Accident
3 Suicide Investigation after deat Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined , fl.
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, o the Funeral Dr
completed filler' Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of prof nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titl€ of certifie cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician JuMonth 9, 20 9 Alexander Jackson, Jr 1333 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Sinai Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 19, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 ★ M 2 🗆 F Months Hours Mary land Director 218-07-1899 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Madral Examiner must be notified at Baltimore 1X Yes 2 No N/A Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21215 5208 Denmore Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ★Yes 2 → No If Yes. Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 spe Black If Yes, Give Year or Dates: 1 □Yes 2 No Specify. þ 3√2 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Post Office Letter Carrier 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosa Burley alexander Jackson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 3435 Paton Avenue Baltimore, Maryland 21215 19a. Informant's Name/Relationship (Type. Print) Alverta Scott-Brooks/Daughter permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of Garrison Forester Wed. Cem. 7/16/10 Owings Mills, MD 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD 21275 Approximate Interval Between Onset and Death 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 year **Physician** disease or condition resulting in death) -schowice /Medical Due to (or as a consequence of): Examiner Lucy O Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physician and s the burial-trans resulting in death) Last Due lo (or as a consequence of) 68760. Physician/Medical attending p Box (IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 | Yes 2 1 No 3 | Probably 4 | Unknown Completed 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🗆 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 [] No 2 ☐ ER/Outpatient 3 ☐ COA 1 ☐ Yes 1 🔲 Inpatient ၉ this o 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending Fath. Division 5 ☐ Pending investigation 1 TYes 2 🗌 No neral Director: / y filled in by the f 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide the Hospital thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belto Ud. 21208 Pristos NO. 1838 Alleu 102 31. Date filed (Month, Day, Year) 32. Registrar Signature State Registrar

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		for State Registrar	State of Maryland / D	Department of Hea Certificate of Dea		ental Hygien Reg. N	2010	21899
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Medic Examin		4a. Facility Name of not institution,	/ /	4b. City, Town, or Loc			Ic. County of Death	S
Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Year If I	Under 24 Hrs. 8 ours Min.	Date of Birth		lace (State or Foreign
Director		219 - 20 - 5450 Usual Residence of Decedent 10a. State 10b. County	, 1 01	Yrs.		Month 8 ay, 1 a	au	<u> </u>
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Dall permi Depar Impor any ir		Vaughn	C. Breeze	5151 Bal-	to. Na	t'I Pik	e (212	29)
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Erik Jordan State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last). Physician/ Month Day July 11, 2010 1855 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 704 North Augusta Avenue **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Director 215-66-386 Country) 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 No Himore WD or 28a-f show i. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Married 1 Never Married Yes If Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced ģ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industr Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) event, the Medical Baltimore, MD 21215-0036 anic 18. Mother's Name (First, Middle, broan me/Relationship (Type, Print (Street and Number or Re ral Route Number Burial 2 Cremation 3 Removal from State Donation 5 Other Specify Six nature of Ifu neral Service Licen 23a. Part I. Entel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death a Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical signed by the attending physician a be detached for use as the burial -UNPENDED AMENDED Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Š 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed Yes 2 V No Yes 2 No 25 Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene After this 1 Yes No 28a Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification Hung Self Natural **FOUND** hours after death.

uneral Director: A
ly filled in by the fi 1 Yes 2 ✔ No Pending Jul 11, 2010 1830 hrs Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 704 North Augusta Avenue, Baltimore, MD determined (Specify) Single Family 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Stgrature and 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E July 12, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD 31. Date filed (Month) egistrar's Signature State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

		•	1 - For Amend Items 25 tate of Ma Registrar	arylanyth Dei	905 (01) P4/20 ertificate of De		eg. No. 010 21901
F 35.	Physici	an	1. Decedent's Name (First, Middle, Last) Glenn Edward	Jones	~	2. Date of Dea Month	pay Year 1/34
J. W.	/Medic Examir	al	4a. Facility Name (If not institution, give street and number)	Jone.	4b. City, Town, or Loc	ation of Death	4c. County of Death
			maryland General He	Spital ge (In yrs. last birthda	Baltimure		1962 9. Birthplace (State or Foreign
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	To the Hc within 24 I To the Fu completel	Medical	one) and manner s		29c. License nu		29d. Date signed (Month, Day, Year)
	7 wit		29b. Signature and title of certifier	M.D.	14	1405	7/8/10
	1		30. Name and address of verson who completed cause of	death (Item 23a) (Tyr	pe, Print)	M / 2-1.	201
	St	at <u>e</u>	31. Date filed (Month, Day, Year) 32 Regist	trar's Signature	ax unique	1 1 21	
	Regist		JUL 14 2010 Cen	a B. A			

Glenn Jones

Tem 18 per fb 2905 7-14710 att and Mental Hygiene AMEND TIEM 18 per FB (905 7/15 10 WS)

Certificate of Death

Reg. No. 21902 State
 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Physician/ Mae Alice Jones ам 2010 1:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Balto If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months (Month, Day, Year) 11-8-1932 77 Director 14-40-7494 N.C. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Framina. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2802 Suffolk Avenue 21215 S IJ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Yes 2 No δ 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2 1 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Private Homes 9th grade <u>Domestic</u> Worker Be 17. Father's Name (First, Middle, Last) 18. Motheris Name (First Middle, Maiden Gurname) ပ္ Leroy Moore Addie Lendora Williams 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Jean Jones-28th Street Balto, MD 1602 E. 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 7-15-2010 | Balto, MD 4 Donation 5 Other (Specify) Woodlawn Cem 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 E. North Avenue 21202 Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition a VOSQUIOC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 J page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Overy Olseose 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specifit CO) မှ 1 🗌 Yes 2 2 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 - Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) undo DICK PCCO 30/Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State 32. Registre Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Cynthia Susan Je		cheid 1- For State Registrar	Stat	e of Maryla		rtment of tificate of		nd Men	tal Hygien	Reg.	201	0	21903
Physicia Medical Examir		1. Decedent's Name Cynthia S		,					Month	of Death	ay Year	3.	Time of Death
		4a. Facility Name (if 207 Nanticol	not institution,		mber)		4b. City, Town, o	or Location		7, 2010	4c. County of D		
Funeral	7	Social Security No.		Sex	7. Age (In yrs. la	ast birthday)	Essex If Under 1 Ye		er 24Hrs. 8, Date	e of Birth(Baltimore	Birthn	lace (State or
Director		214-80-12	'	M 2 X F	46	Yrs	Months Da	ys Hours	Min. Aug	.21,1	1963	Count	Baltimore, Maryland
any	ł	Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Locati	on					- 1	0d. Inside City Limits
yland a-f show	ğ	Maryland 10e. Street and Num		1 County	Fir	nksburg	10f. Zip Code	<u></u>		100	Citizen of What		Yes 2 No
the Mar Sa or 28	Director	3001 Carr		Road				21048		log.	United	_	
ath with items 2.	Funeral	11. Marital Status 1 Never Marrie	d 2 Marri	ed Armed Fo	edent Ever in U.				gin? (Specify Yes , Puerto Rican, et		14. Race - A White, e		n Indian, Black,
after de	by Fu	3 Widowed		1 Yes ed If Yes, Give Year or Dates:		1		o specify:			Specify:		ite
72 hours		15. Decedent's Edit		only highest grad			t's Usual Occupa ost of working lif		kind of work done use retired)	16	6b, Kind of Busin	ess/Indi	ustry
215-0036 be filed within 7 intal Hygiene riked other than ent, the Medica	Completed	10 17. Father's Name (I	First Middle La	N/	A		Unemp.	-	's Name (First, M	iddle Mei	Unem	plo	yed
215- be filed mtal Hyg rked otl	Be	Curtis Ho	ward Mo	rris				Patı	ricia An	n Pou	ılsen		
MD 21 d 2 should I dth and Mer n 27 is mar numatic ev		19a. Informant's Nar Mr. Curti:			(Father)		Address (Streen		nber or Rural Rou Port		r, City or Town, S sit, Mary		
	Ì	20a. Method of Disp		3 Removal fro		Place of Dispos	ition (Name of co	emetery,	July 13,	20	Oc. Location - Cit	ty or To	
Baltimore, permit. Pages I ar Department of Hee, Important: If ite	-	_	Other Spec	ify:	C	emetion!	ervices.	Inc.		F	'oxest Hi	11,	Maryland
Ba perm Depr Imp		p	7 7.	- your	4		325 York	Road	ves Funera Timonium	ı. Mar	vland 21	ente 1093-	r. P.A. 2215
Physician · /M i i		23a Flart I Enter the	one cause on	ach line.		Do not enter th	e mode of dying	g, such as ca	ardiac or respirat	ory arrest,	shock, or heart		Approximate Interval Between Onset and Death
Examiner	1	Immediate Cause (F or condition resulting		a. Drowni Due to (or as a	consequence of):						\top	
	Je	Sequentially list con if any, leading to immorause. Enter Under	mediate	b. Due to (or as a	consequence of):						+	-
d Sit	Examiner	(Disease or injury the events resulting in d	at initiated	c. Due to (or as a	consequence of):						+	
	edical	X UNPENDED		dAMENDED	07.00	C	T - 00 C	7/15/	1.0 mm			+	
760, ficate be example 3 physiciar the burial		IF FEMALE: 23b. Was decedent p	regnant in the	23a, 23c. If yes, o	27,28a-	nancy					23d. Date of del		V
OX 68 ath certi	Physician/M	past 12 months?		4 Pregna	ant at time of dea	oth -	al death 3 ner (Specify)	Ectopic	pregnancy		Month	Day	Year
O. Bo at the de d by the tached f		Part II. Other signifi		9 Unkno		sulting in the u	nderlying cause	given in Pa	rt I. 23e.	Did tobac	cco use contribut	e to the	cause of death?
S, P.	ed by					 .	· · · · ·		1[ly 4 Unknown
e faw ree has be	Completed								_	Was an autopsy performed	prior d? deat	to com	sy findings available ipletion of cause of
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2.	မှု Be	25. Was case referre examiner?	ed to medical		-		26.Plac		(Check only one)	Yes 2	NO 1	Yes	2 No
of Vid	의		No	28a. Date of	of Injury	ER/Outpatient 28b, Time of Ir		Other4	Nursing Home ? 28d. Des		sidence 6 🗸 C	ther: So	ene
sion (trending death. ctor; Al	ation	1 Natural 2 Accident	5 Pending	E 1 7 /	7 / 2010	Fd 1:30	pm 1	Yes 2X					
Divis tal or A ral Direc	Certification:	3 Suicide 4 Homicide	6 X Could no determin	ot be	of Injury - At ho	me, farm, stree iver	t, factory, office	building, etc	c. 28f. Loca or To Nant	ation (Street own, State 1COK	etand Number of Fd Pier e Rd Ess	ex.	Route Number, City MD
9-2		29a. Certifier 1 C		ician: To the best er:On the basis o	-				ce, and due to the	e cause(s)) and manner as	stated.	
To t with Com	Medical	29b. Signature and to		and manner st			29c. Licen				d. Date signed		
		Car	of H	alla	0		O.C.	.M.E.		J	uly 8, 2010		
R		30. Name and addres Carol Allan, I		o completed cause tant Medical E	,	,	treet, Baltim	ore, MD	21201				
Sta Registr		31. Date filed (Month	, Day, Year)	32. Rec	tor's Signatur	re # 1							
DHMH 17 Rev 1/200			UL 1 1	OCA OCA	TE	ORIGINAL							

10-05172 Aloisia Kranz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 21904

	1- For State Registrar	Certificate	e of Death	Reg. N	No.	
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)	Aloisia Kranz		2. Date of Death Month Da July 10, 2010	y Year	ime of Death 537 hrs
	4a. Facility Name (if not institution, give stree 11 Filbert Court	t and number)	4b. City, Town, or Location of De Gaithersburg	eath	4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last birthda	·	Win. 8. Date of Birth (M	M/DD/YYYY) 9. Birthpla Foreign Country	ce (State or Austria
yland -f show any once. tor	Usual Residence of Decedent 10a. State	10c. City, Town or L	Gaithersburg		10d	. Inside City Limits Yes 2 X No
ath with the Maryland items 23a or 28a-f show ust be notified at once.			10f. Zip Code 20879	10g. (Citizen of What Country? Austria	
한 등레 교	11. Marital Status 1 X Never Married 2 Married 1 3 Widowed 4 Divorced	rmed Forces? Yes 2 X No	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American I White, etc.	
5-0036 ed within 72 hours after a fygiene. other than "natural", the Medical Examiner Completed by	15. Decedent's Education (Specify only high Elementary/Secondary (0-12) 12	duri	edent's Usual Occupation (Give kind ng most of working life. DO NOT use	retired)	rivate Duty	try
21215-0036 hald be filed within 7 Mental Hygiene. marked other than cevent, the Medica	17. Father's Name (First, Middle, Last)	NU		me (First, Middle, Maid		Care
215- be filed ntal Hyg rked off ent, the		Kranz	Barba		Asn	er
21. S mar To	19a. Informant's Name/Relationship (Type, Pr	int) 19b. M	ailing Address (Street and Number			
MD d 2 sh fth and th 27 is	Olivia C. Kranz, nied		1 Kennewick Avenu	ie Takom	a Park, MD	20912
Baltimore, MD 2121. permit. Pages I and 2 should be fil Department of Health and Mental Important: If item 27 is marked injury or other traumatic event, To Be	20a. Method of Disposition 1 Burial 2 X Cremation 3 Rer 4 Donation 5 Other Specify:	noval from State crematory of Metro C	sposition (Name of cemetery, or other place) rematory, Inc. 07	Date 2007/12/10	c. Location - City or Town Baltimore.	n, State
Baltimo permit. Pag Department Important: injury or ot	21. Signature of Funeral Service Licensee	eorge MacNabb	22. Name and Address of Facility C1	remation So	ciety of MD	. Inc.
Physician /Medi_I	23a. Part I. Enter the disease, or complication failure. List only one cause on each line. Immediate Cause (Final disease a.	s that caused the death. Do not en Atherosclerot Complicated by	ic Cardiovascular	c or respiratory arrest, s Disease	shock, or heart Ap	proximate Interval atween Onset and Death
Examiner	or condition resulting in death) Due to	(or as a consequence of):	пурстынаты			
ted 1 ansit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	or as a consequence of):				
execu ian and ial - tra	d	NDED 23a,27,28a-	f per me g906 8-2	24-10 vt		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 9	If yes, outcome of pregnancy Live birth 2 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic prec		23d. Date of delivery Month Day	Year
, P.O. E res that the d signed by the be detached d by Phy	Part II. Other significant conditions contrib	uting to death but not resulting in t	he underlying cause given in Part I.		ouse contribute to the ca	
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certif hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending appletely filled in by the funeral director, page 2 should be detached for use as direal Certification: To Be Completed by Physician				24a. Was an autopsy performed 1 Yes 2		findings available etion of cause of
ital Fician: Secretific	25. Was case referred to medical examiner?		26.Place of Death (Chec			
F Vite	1 ✓ Yes 2 No	T The state of the	ient 3 DOA Other Nur	sing Home 5 Resid	dence 6 Other: Scer	ne
ion of tending Ph Beath. tor: After t t the funeral	1 Natural 5 Rending	28b. Time (Month, Day, Year) 1 7-10-10	4 - X - 2 - X -	28d. Describe how in exposed to	o hot envir	ject onment
Division of spiral or Attending hours after death. Inneral Director: After the function of filled in by the function: Certification:	3 Suicide 6 Could not be 28	e. Place of Injury - At home, farm, pecify) hou:		28f. Location (Street or Town, State) 11 Filber	and Number or Rural Roct Ct. Gaith	ute Number, City ersburg,
To the Hoss within 24 hos To the Fun completely iedical (one) 2 Medical Examiner: On the		ccurred at the time, date and place, a tigation, in my opinion, death occurred			se(s)
Ne T × T 22	29b. Signature and title of certifier Wayste The Yl	rel	29c. License number O.C.M.E.		I. Date signed (Month, Da ly 11, 2010	ay, Year)
end	30. Name and address of person who complete Margarita Korell MD. Assistan		Penn Street, Baltimore, MI	21201		
State Registrar		32. Registrar's Signature	harles			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 **Gloria** Kulp 7:08p Marion Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pasadena East Shore Road <u> Anne Arundel</u> 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland Maryland Months 1 M 2 X F Hours March 5. **Director** 214-40-2508 87 1923 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Numbe 10g. Citizen of What Country? Funeral 933 Andrews Road 21060 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Bank Auditor Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) James Clinton Jones Marion Virginia Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7774 East Shore Road, Pasadena, Maryland 21122 Marion Gloria Funkhouser, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7/13/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one caus on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) YEAY Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Yes 2 🔀 No 3 Probably 4 Unknown is certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes Yes 26. Place of Death (Check only one) Be Was case referred to medical examiner? Daughter's
4 □ Nursing Home 5 □ Residence 6 H Other (Specify)Residence 2 EXNo မ 1 Inpatient 2 I ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the Suicrae
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

30. Name and address of person who

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

ompleted cause of death (Item 23a) (Type, Print)

29c. License number

305

011

2106

Robert James Morgan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 21906 Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month D July 9, 2010 Medical Examiner 1818 hrs Morgan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** 4404 Silverbrook Lane Owings Mills 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Months Hours Min Director Country) IL 7/30/1949 351-42-5081 1 X M 2 F 60 Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 X No items 23a or 28a-f show ust be notified at once. Baltimore Owings Mills permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified as once Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4404 Silver Brook Lane 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 X Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White Specify: Vietnam \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 5 Sweetheart Cup Co. Manager 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be James Morgan Rosemary Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 216 Mill Pond Drive Exton, PA Colleen Rothhaar Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State crematory or other place) Carroll Cremation Ser 7/13/2010 Hampstead, MD 4 Donation 5 Other Specify 22. Name and Address of Facility Sur an re of Funeral Service License 11824 Reisterstown Road Reisterstown, MD 21136 ELINE FUNERAL HOME 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /M. dica Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical AMENDED 23a, 27 pe rme g906 8-17-10 vt **X** UNPENDED attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed icate has been s 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

certificate has Hospital or Attending Physician: Division of Vital this After Director: I in by the f 24 hours after death To the 1 within 2

30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. State Registrar

1 🗸 Yes

27. Manner of Death

Accident

Homicide

29b. Signature and title of certifier

Marie

1 X Natural

3 Suicide

2

Medical

2 No

5 Pending

6 Could not be determined

> Assistant Medical Examiner 32. Registra 's Signal Control

nell

Hospital: 1 Inpatient 2

28a. Date of Injury (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Other Nursing Home 5 Residence 6 🗸 Other: Scene

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City

July 10, 2010

29d. Date signed (Month, Day, Year)

ER/Outpatient 3

28e. Place of Injury - At home, farm, street, factory, office building, etc

29a. Certifier (Check only one)

29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28b. Time of Injury

DOA

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 13^y 2ŎĨŌ 7:10 a^M Alfred George Meikle john Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arunde1 Cornhill Street 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Months Hours Jan. 10, Director 217-34-8013 Maryland **1**938 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10c. City, Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified 1 🗌 Yes 2 🙀 No Maryland | Anne Annapolis 4 8 1 Arunde1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21 Cornhill Street 21401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White etc. 1 Never Married 2 Married Completed by 1 Yes : 2 X No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 1 Yes 2 No Specify "natural", Specify: White Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bricklayer Masonry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James A. Meiklejohn Bernice P. Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice V. Meiklejohn, Wife 21 Cornhill Street, Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State o = 0 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State cemetery, crematory or other place permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 7/14/2010 Baltimore, Maryland Metro Crematory, Inc. 21. Signature of Funeral Service License Ananda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 Dec sto 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician; The law requires 1 Ses 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) After this mpleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Funeral L edical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year, who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 10:15 AM TULY 2010 Mary Elizabeth Milstead /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BRIGHTWOOD CENTER GENESIS Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2**X X** Hopewell, VA 212-28-8816 79 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐Yes 2 XNo Baltimore Towson Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 ner must be n U.S.A. 21204 7925 York Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 0 1 ☐ Yes 2 💢 No Specify: Specify: þ 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AAI Corporation Executive Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Gertrude Baker Talmage DeWitt Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Department of Health a Important: If Item 27 is any Injury or other tra once. 20 Cavan Drive, Lutherville, MD 21093 Laura Fenske/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 07/15/2010 Timonium, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, MD 21204
Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death THRIVE Immediate Cause (Final disease or condition resulting in death) FAILURE -Physician /Medical Due to (or as a consequence of): ENCEPHALOPATHY ANOXIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Be P Certification:

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

with the Maryland

2 should be filed within 72 hours after and Mental Hygiene.

1 and 2 should

Pages 1

Maryland 21215-0036

Baltimore,

attending physician and for use as the burial-trar

	and the second				24a. Was an autopsy performed? 1∐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case refer	rred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 [OOA Other: 4 Nursing I	Home 5 ☐ Residence 6	G ☐Other (Specify)
27. Manner of Dead 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifler (Check only one)		nysician: To the best of my kno miner: On the basis of examina and manner stated.				

29c. License number

D0061789

29d. Date signed (Month, Day, Year)

2010

State Registrar 29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOPRAINE OFORT AWUAH, MO, 5430 CAMPBELL BLVD STE 214. BALTIMORE MD 21236

32. Registrar's Signature 31. Date filed (Month, Day, Year)

fin Anuch MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ uiq, Manelli Ö Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Elizabeth Rehab and Nursing Center Baltimore N/A Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days 220-36-6049 **1**915 Pennsylvania Director Usual Residence of Decedent 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1003 Spring Gate Road, Unit 2B 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Š 1 Never Married 2 X Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) . Page 1 and 2 should be filed within 72 iment of Health and Mental Hygiene. tant; If item 27 is marked other than ' College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Artist Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guiliano Manelli Maria D'Angelo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cristina Manelli, wife 1003 Spring Gate Rd., Unit 2B Catonsville,MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. Dulaney Valley Mem Grdns 7/15/10 | Timonium, MD Donation 5 🗋 Other (Specify) 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee George MacNabb 301 Frederick Road Catonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, dementic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to jor as a consequence of attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown BPH Were autopsy findings available prior to completion of cause of death? 24a. Was an has After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᅆ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Caro R111615 7112110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benson Avenue

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:50P.M Duk No Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Korea 213-96-4771 1 □ M 2 🛛 F Months Days Hours Min T92<u>0</u> **Director** 90 Jan. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 20a-4 ehm 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Severn 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8205 Autumn Lake Court 21144 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 → Widowed 4 □ Divorced If Yes, Give Year or Dates Specify: Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed Store Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Jun Choon No / Son 6232 Jean Louise Way, Alexandria, VA 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Atlantic Crematory 7/11/2010 4 Donation 5 Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 21. Signal M01364 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death accu Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to transaction cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine builto for as a conseduence of To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year signed by the a ld be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 □ Probably 4 □ Unknown is certificate has been s director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျ 1 Tyes 1 Ninpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in 24 hours after death.

he Funeral Director: After this pleted filled in by the funeral di this Manner of Death
Natural
Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation

Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or invosing and Certifying Nurse Practioner: To the best of my knowledge, death only one) occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar Name and addre

1061.

rson who completed cause of death (Item 23a) Type, Print)

32. Registrar

			1 - For State Registrar	Otate of Marylan	•	rtificate of		, ,	eg. No.	
I	Physici	on	1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic		VIRGINIA	OLDEN		T		JULY	13 2010	
	Examir	ner	4a. Facility Name (If not institution, given	· ·			or Location of Death		4c. County of Dea	
£	Funeral	_	HCR-MANOR CARE - 5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday,		If Under 24 Hrs.	8. Date of Birth	BALTI 9. Bir	thplace (State or Foreign
	Director		098-20-7120 Usual Residence of Decedent	□ M 2 🛣 F 83	Yrs.	Months Days	Hours Min.	JULY 11,	Year) Co	PA
	land		10a. State 10b. County	10c. Cit	y, Town or L	ocation				10d. Inside City Limits
	n the Maryland r 28a-f show motified at	cto	MD	BA	LTIMO	RE				1 Kayes 2 No
	with the	Director	10e. Street and Number 833 W. PRATT S	STREET		10f. Zip Code	21201		0g. Citizen of What Co USA	ountry?
٥	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show is Madeal Environe roust he notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1	S. 13.	Was Decedent of H If Yes, specify Cub 1 □Yes 2 ★ No	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Pican, etc.)	14. Race - Ame Black, Whit	
2-003b	hours ntural",	ed by	3 X Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a. Dece	edent's Usual Occur	pation	- 1	Specify: 16b. Kind of Business	RI.ACK /In:ustry
<u>ე</u>	within 72 iene. than "nal	Completed	(Specify only highest gra	ade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work d)	king		,
7	7.00	Co	Elementary/Secondary (0-12)		HO	EMMAKER			HOME	
E	be d d	Be	17. Father's Name (First, Middle, Last	unk.			18. Mother's Nam	, ,	Maiden Surname)	
	id 2 should be ith and Menta 27 is marked 1 traumatic ev	ပ	19a. Informant's Name/Relationship ((Type, Print)	19b. Maili	ing Address (Street			; City or Town, State,	Zio Code)
<u>S</u>	and 2 sealth ar		SCOTT OLDEN/SON	.,,,,,		,	FORGE WAY		ON, MD 210	
ore,	는 로 보고		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	20b. F	lace of Disperent	osition (Name of matory or other pla	ce)	Date	20c. Location - City or	Town, State
Ĕ	Pages Iment of Iant: If Ite		4 Donation 5 Other (Special	Hemovai from State	SITE	CREMATORY	7-1	4-2010		E, MARYLAND
<u> </u>	permit. Pages Department of Important: If I any Injury or once.		21. gnature of Funeral Service Licer	nsee To			ess of Facility JAM AURENS ST			S F.H., INC. 21217
	Physician /Medical Examiner		23a. Par . Enter the disease, or com shock, or heart failure. List only Immed the Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence).	n. Do not en	tex the mode of dyi		or respiratory arr		Approximate Interval Between Onset and Death
00100	rtificate be executed ng physician and as the burial-transit	Medical Examiner	if any, leading to infinitellate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
O. DOX	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after decret within 24 hours after decret. The the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnate 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	□ Ectopic pregnand □ Other (specify) _	су		23d. Date of de Month	olivery Day Year
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שו שבני	t. The law re cate has be page 2 sho	Completed						24a. Was a autops perform	y prior to ned? death?	utopsy findings available completion of cause of s 2 No
2	siclan certif rector	B	25. Was case referred to medical examiner?	Hospital:		Oth	or: [th (Check only on	·	
NISION OF	ding Phys th. After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	of 28c. Inju	4 Nursing H		ence 6 Other (Spenser of Other	ecify)
	tal or Atter s after dea al Director ed in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not b determined		ome, farm, st y)	reet, factory, office		28f. Location (Si City or Town	reet and Number or Fi n, State)	Tural Route Number,
	he Hospil in 24 hour he Funera pletely fille	Medical (29a. Certifying Pt (Check only one) 1	nysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, dea tion and/or it	nvestigation, in my	opinion, death occu	rred at the time, d	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
	vith voint	Σ	29b. Signature and attle of certifier	11.10		29c. Licens			9d. Date signed (Mon	
			30. Name and address of person who	CRNP	23a) /Tune	Print)	100216		1/13/201	21204
	2		ANNE OBI,	6761 M Charle	5 54	, Buite	4105, 5	Bactimon	ze, MD	21204
	Sta Registr		31. Date filed (Month, Day, "Year)	32. Registral Signa	ture					

DHMH 17 Rev 1/2001

10-02259 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 1 0 State of Maryland / Department of Health and Mental Hydione

UNK UNK	State of Maryland / Department of H 1- For State Registrar Certificate of D	eath	eg. No.
Physician/	1. Decedent's Name (First, Middle,Last)	2. Date of Deat Month	th 3. Time of Death
andical Examine	Date D. Ray Dr.	March 20, City, Town, or Location of Death	2010 1255 hrs
		Saltimore	N/A
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	f Under 1 Year If Under 24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Birthplace (State or
Director	217-96-6213 1 1 KM 2 F 29 Yrs. Musual Residence of Decedent	Months Days Hours Min. 01/28	/1981 Foreign Country) MD
gue,	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
show ince.	MD N/A	Baltimore	1 X Yes 2 No
the Maryland a or 28a-f show tified at once. Director	10e. Street and Number	Of, Zip Code	0g. Citizen of What Country?
th the 23a or notifie	4302 Plainfield Ave.	21206	U.S.A.
r death with or or items 23: must be not		ecedent of Hispanic Origin? (Specify Yes or No specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
s after niner	3 Widowed 4 Divorced in test, sive year or Dates:	s 2 No specify: Jsual Occupation (Give kind of work done	Specify:Black 16b. Kind of Business/Industry
5-0036 ed within 72 hour hygiene. other than "natu the Medical Exar Completed	15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+)	of working life. DO NOT use retired)	Top. Kind of business/industry
136 thin 7; than than edical	12th Grade unload	lina	Target Warehouse
5-0(Hygier other the M		18.Mother's Name (First, Middle, M	Maiden Surname)
121 d be fi lental] arked went,			hnson
Should and Me 7 is ma natic even To		dress (Street and Number or Rural Route Num Plainfield Ave., Ba	
and 2 and 2 fealth item 2 traum	20a. Method of Disposition 20b. Place of Disposition	(Name of cemetery, Date	20c. Location - City or Town, State
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumantic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Burial 2 Cremation 3 Removal from State Joseph Br 4 Donation 5 Other Specify:		Baltimore, MD
Balf permit Depart Impor injury		Sephreno Fabrown Jr. 1 O N. Fulton Ave., Ba	
Physician // // // // // // // // // // // // //	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.	node of dying, such as cardiac or respiratory arro	Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrythmia Due to (or as a consequence of):		Death
<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
60, Ite be executed Physician and E burial - transit	d		
50, se be execut ysician and burial - tra	☑ UNPENDED ☐ AMENDED 23a,27 per me	g908 10-18-10 vt	
Vital Records, P.O. Box 6876 ysician: The law requires that the death certificate his certificate has been signed by the attending phy director, page 2 should be detached for use as the OBE Completed by Physician/M			23d. Date of delivery Month Day Year
Sox death of e atten I for us	1 Yes 2 No 9 Unknown 9 Unknown	(Specify)	
O. E at the diby the trached		rlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?
ires that signed be deticated by		1 Yes	s 2 🗸 No 3 🗌 Probably 4 🔝 Unknown
Records, The law requirer fricate has been sig page 2 should be Completed		24a. Was autop	prior to completion of cause of
Reco		perfor 1 ✓ Yes	rmed? death? 2 No 1 ✓ Yes 2 No
tal Ficiani: Certific rector, F	25. Was case referred to medical	26.Place of Death (Check only one)	
Physic Physic ar this or To E	1 Yes 2 No Impatient 2 ER/Outpatient 3		Residence 6 Other: Scene
Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be ra after death. Solitorian After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the bur errification: To Be Completed by Physician/Med		y 28c. Injury at Work? 28d. Describe f	how injury occurred
Division o spital or Attending tours after death. neral Director: Aft filled in by the func Certification:	3 Suicide 6 Could not be determined (Specify)	actory, office building, etc. 28f. Location (\$ or Town, S	Street and Number or Rural Route Number, City State)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex			
T viii V	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Mayorie Mr. Chill	O.C.M.E.	March 21, 2010
Ø	30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penr	n Street, Baltimore, MD 21201	1
State	31. Date filed (Month, Day, Year) 32. Registraris Signature		
Registra			OCME
DHMH 17 Rev 1/2001	ORIGÏNAL		- white

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ramah Jamanuel Reid State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Time of Death Month **Medical Examiner** 0904 hrs July 7, 2010 Ramah J. Reid 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5219 Cuthbert Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland Min. Months Davs Hours Sept.2,1983 Director 213-06-6826 1 X M 2 F 26 Yrs Usual Residence of Decedent any 10b. Count 10c. City, Town or Location 10d. Inside City Limits 10a. State s 23a or 28a-f show : e notified at once. Maryland Baltimore N/A1 X Yes 2 No more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Montal Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 5606 Winner Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc 1 Never Married 2 Married Yes 2 X No _{so}Black 3 Widowed 4 Divorced f Yes, Give Year Yes 2 X No specify. <u>چ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Spice Factory Factory worker vears 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Patrick Reid June Cedenio 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State Zip Gode) 4015 Mortimer Ave Baltimore, MD 21215 19a. Informant's Name/Relationship (Type, Print) June Cedenio/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 7/16/10 woodlawn, Maryland King Memorial Park Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility d Address of Facility Chatman-Harris Funeral Home Reisterstown RD Baltimore, MD 21215 5240 Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Gunshot Wound of the Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - tran sician/Medical UNPENDED AMENDED 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for Unknown signed by the a Phys 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ٦. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed this certificate has been a il director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other: Scene ို ✓ Yes 2 After t 28a. Date of Injury FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot FOUND: Division Natural To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: 1 Yes 2 V No 5 Pending filled in by the Jul 7, 2010 0855 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide or Town, State)
5219 Cuthbert Avenue, Baltimore, MD (Specify) Yard 4 V Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State 31 Date filed (Moralh, Par) Registrar

29b. Signature and title of certifie

Russell Alexander MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's ignatur

29c. License number

O.C.M.E.

July 8, 2010

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 2. Date of Death 1. Degedent's Name (First, Middle Last) Day Year **Physician** 2026 July Kod rown 2010 /Medical 4a. Facility Name (If not institution, give street 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore Saint Agnes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 □ M 2 🗹 F 248-51-5248 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 10a State 10h County MD 1 Yes 2 □ No Funeral Director timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA licott 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XXNo þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be lenr ပ oa Town, State, Zip Code) to. tusband Baltimore, 20c. Location - City or Town, State 20a. Mathod of Dispo-1 ☐ Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donation 21. Sig 1 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart value. List only one cause on each line. immediate Cause (Final **Physician** 3 hours Acute nunocordial disease or condition resulting in death) /Medical Due to (or as a construence of): Examiner ardiomy opa thy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Coronary arteny
Due to (or as a consequence of): disease and burial-tran the attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☑ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Example 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe D0068107 11,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Caton Avenue Villarrea 900 MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 2

		1 - State Registrar	, , , , , , , , , , , , , , , , , , , ,	Cen	tificate of De	eath		Reg. No.		
Physici Med		1. Decedent's Name (First, Middle, Last) Helen M. Real	nl				2. Date of Dea Month		.E.,EYear	3. Time of Death
Exami		4a. Facility Name (If not institution, give street an	d number) dical Cent	en to	4b. City, Town, or L	ocation of Death	17	4c. Co	bunty of Death Balti	TOPE
Funera Directo		5. Social Security Number 6. Sex 1 □ M 2	7. Age (In yrs. lat 83	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Dat Aug. 25	h ^(, Year) • 1926_	9. Birth Co <i>ur</i> Pen	place (State or Foreign htry) nsylvania
Maryland Ba-f show tified at	rector	Usual Residence of Decedent 10a. State 10b. County MD Baltimore		Town or Loc Parkv						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
with the Ps 23a or 2	Funeral Director	10e. Street and Number 8800 Walther Blvd	4208		10f. Zip Code 21234	1		10g. Citizer	U.S.A.	
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. red other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 If Y Yea	s Decedent Ever in U.S. ned Forces? Yes 2 X No as, Give r or Dates.		/as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 🏻 No		ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: Whi	etc.
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade complete of the complete	oleted) ege (1-4 or 5+)	(Give k	ent's Usual Occupation of work done dual NOT use retired) NUTSE		ing		of Business In Seph M er	
/land : d be filed v Mental Hyg arked othe rtic event,	To Be	17. Father's Name (First, Middle, Last) William J. Rando	Lph			18. Mother's Nam Mary	e (First, Middle, Ærdin g	Maiden Sun	name)	
more, Marylanc age 1 and 2 should be file ont of Health and Mental H tt: If item 27 is marked of y or other traumatic ever		19a. Informant's Name/Relationship (Type, Print Kathleen R. Auth/I			g Address (Street and lemore I					
Baltimore, IN: permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 🎇 Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	al from State 20b. Pla	netery crem laney moria	ition (Name of atory or other place) Valley 1 Garder	July ns 20		Timoni	ion - City or To . um , Ma	ryland
balt permit Depart Import any inj		21. Signature of Funeral Service Licenses	ais	22. E 8	Name and Address Vans Fur 800 Harf	of Facility n eral Cha ord Rd.	pel & Cre Parkville	enetico e, MD 2	Servi 1234	œs
Priysician		23a Parl 1. Enter the disease, or complications shock, or heart failure. List only one cause implediate Cause (Final disease or condition		Do not enter	the mode of dying,					Approximate Interval Between Onset and Death
Medica Examine	ı	Sequentially list conditions h	ue to (or as a conseque CHRONIC O	BSTRU	CTIVE PL	JLMONAR	Y DISE	ASE		
scuted and transit	xamine	cause. Enter Underlying Cause (Disease or iinjury that initiated events c	ue to (or as a conseque ISCHEMIC ue to (or as a conseque	COLTTI					į.	
ra / oU tificate be executed ng physician and s as the burial-transit	Medical Examiner	d.	ue to for as a conseque	ince org.						
box of death cert he attendir ed for use	Physician/Me	in the past 12 months?	es, outcome of pregnan] Live Birth 2	death 3 🗌	Ectopic pregnancy Other (specify)			23d	I. Date of deliv Month	ery Day Year
S, F.C. lires that the signed by ti		Part II. Other significant conditions contributin	_	Iting in the un	derlying cause giver	n in Part I.				ne cause of death?
fecords, he faw requires te has been sig age 2 should b	Completed by	URINARY TRACT I	NFECTION				24a. Was a autop	an 2 sy rmed? 2 X No	4b. Were auto prior to co death?	psy findings available mpletion of cause of
ian: T ian: T ian: T ian: T ctor, p	Be C	25. Was case referred to medical examiner?			26. Plac	e of Death (Check		ZINO	i 🗆 ies	2 6 140
VICAI hysician his certifial al director	은	1 🗆 Yes 2 风 No	1 X Inpatient 2 DE			4 U Nursing Ho				0
ION OT tending Pl leath. or: After th the funeral	Certificate:	27. Manner of Death 1 📉 Natural 5 🗌 Pending 2 🗋 Accident 3 🗀 Suicide 6 🖂 Could not be	Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury a work? M 1 ☐ Ye	t es 2 □ No	28d. Describe h	ow injury oc	curred	
DIVISION ital or Attendii urs after death. ral Director: Alled in by the fu		4 Homicide determined 28e.	Place of Injury - At hom building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (S City or Tow		umber or Rura	l Route Number,
the Hosp in 24 hor he Fune.	Medical	29a. Certifier (Check (Check only one) (Check one) (Check only one) (Check one	he basis of examination	and/or investig	gation, in my opinion,	death occurred at	the time, date a	nd place, and	d due to the ca	use(s) and manner stated.
To t with Com		29b. Signature and title of certifier	inthieu	mb	29c. License n				igned (Month, Zーしこ	
101		30. Name and address of person who complete RICHARD L. LINTHIC			osler Di	RIVE T	OWSON.	MARY	LAND	E1204
Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign tu	re	·					

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		1 - For Amend I	tem State o	f Marylar	od / Depa 905,077 Cer	artment of 14/2010 tificate of	Health dhb Death	and N	Mental Hy	gienez Reg. No.	010	21916
Physicia Medic	al	1. Decedent's Name (First, Middle	ROSE	NB	ERO				2. Date of De Month	Day	2010	3. Time of Death
Examin	er	4a. Facility Name (if not institution, SEASONS HOSPICE 5. Social Security Number	6. Sex		SPITAL ast birthday)	If Under 1 Yea	ALLST(OWN 24 Hrs.	8. Date of Bir	BAL	unty of Death TIMORE 9. Birthp	place (State or Foreign
Director	<u>.</u>	050-18-8106 Usual Residence of Decedent 10a. State 10b. County	1 □ M 2 💢 F	91	Yrs.	Months Day	rs Hours	Min.	12/31/3	r978 	Count	NY Od. Inside City Limits
ne Mary or 28a-f notifie	Director		ALTIMORE	100. 011		IMORE	9			10g. Citizen	of What Coun	1 ☐ Yes 2 🏋 No
death witi items 23 ner must	d by Funeral	16 OLD COURT F 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dece Armed Fo 1 Yes	edent Ever in U. rces? 2 X No re	ŀ	Vas Decedent of Yes, specify Cu	ıban, Mexicai	n, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, e	
I and 2 should be flied within 72 hours after f Health and Mental Hygiene. item 27 is marked other than "natural", or other traumatic event, the Medical Exami	e Completed	15. Deceder (Specify only higher Elementary/Seconday (0-12) 12	t's Education st grade completed) College (1		(Give I life, D	lent's Usual Occ kind of work don O NOT use retire	e during mos	it of work	ing		of Business Inc	OFFICE
buld be filed wil d Mental Hygie marked other matic event, th	To Be	17. Father's Name (First, Middle, L SHLOMO Green	feld	G	REENFI		RAC	CHEL	e (First, Middle,	UNKNO	DWN	
and 2 should Health and M tem 27 is mar ther traumat		19a. Informant's Name/Relationsh RHONA PLUNKA/Da 20a. Method of Disposition		20h F	2301	FARRING sition (Name of		OAD,		ORE, M		09
permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once.		1 A Burial 2 Cremation 4 Donation 5 Other (S 21. Signature of Funeral Service L	pecify)	State	TH MOS	ES CEME	ΓERY	7/9,	/2010	PINE	LAWN, I	NY
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Physician/ Medical		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	_ a. <u>_</u> <u>@</u>	or as a consequ	al Jence of:	Thr	/h	60	256			Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. ———	or as a consequ	,						-	
cate be executed physician and the burial-transit	dical Exa	that initiated events resulting in death) Last	c. Due to ((or as a consequ	uence of):							
ath certifications attending for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No g ☐ Unknown	1 Live	come of pregna Birth 2 Feta nant at time of one	al death 3	Ectopic pregna Other (specify)	ancy			23d	. Date of delive	ery Day Year
uires that t n signed b uld be deta	ed by P	Part II. Other significant conditio	ns contributing to d	eath but not res	ulting in the u	nderlying cause	given in Part	I.				ne cause of death?
To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached	Somplet								24a. Was autor perfo			psy findings available mpletion of cause of 2 No
ysician: is certific director,	To Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien		Place of Dea				Other (Specify)	re .
tending Preath. or: After the funeral	Certificate:	27. Manner of Death 1 Natural 5 □ Pending 2 Accident Investig 3 □ Suicide 6 □ Could r	ation	of injury th, Day, Year)	28b, Time of injury		ury at ork? Yes 2		28d. Describe h	ow injury oc	curred	
oital or Att		4 Homicide determi	ned 28e. Place buildir	ng, etc. (Specify	·)	et, factory, offic			City or Tov	ın, State)		Route Number,
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2° Medical E	Physician: To the b kaminer: On the bas Nurse Practioner:	is of examination	and/or invest	igation, in my opi leath occurred at	nion, death o	ccurred at	the time, date a	ind place, and e cause(s) and	d due to the cau	use(s) and manner stated ated.
1 .		30. Name and address of person v	the completed caus	of death (Item	1 23a) /Time P	- Do	158	27	2	Jul.	98,	2010
Ų √ Stat		31. Date filed (Month, Day, Year)	32. R	3934	AUI	441	ch/	8/0	N-50	7. XP.	N2	1061
Registra		2000 9 4	20010			and B						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death Reg. No 1, Decedent's Name (First, Middle, Last) 2. Date of Dea 3. Time of Death Physician/ Kosen Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min 0873071924 Country Director 219-12-7167 85 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3200 OLD POST DRIVE, #7 21208 USA 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Armed Forces? Black, White, etc. ò ģ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. WHITE "natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
UNIVERSITY OF MARYLAND (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the SECRETARY BALTIMORE COUNTY any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F မ GREENSTEIN ABRAHAM DINA KALICHMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health stem 27 is COLEMAN ROSENTHAL/HUSBAND 3200 OLD POST DRIVE, #7, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State permit. Page 1 and Department of B Important: If 1 XBurial 2 Cremation 3 Removal from State Ponation 5 Other (Specify) BETH EL MEMORIAL PK.: 7/13/2010 RANDALLSTOWN, MD Signature of Funeral Service Lipens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD art 1. Enter the disea e. c complications that caus shock, or heart failure. List only one cause on each inthe death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final e REBRAC Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a considernce of if any leading to immedicause. Enter Underlying Cause (Disease or iinjury Exami and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy death? 2 No 1 Tes Yes To the Hospital or Attending Physician: "within 24 hours after death."

To the Funeral Director: After this certified 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No ျှ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Box 68760

P.O.

Records,

Division of Vital

		-	1 - State of Maryland / Dep	partment of leartificate of	Health and <i>Death</i>		iene20 l	0 21918
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Chris Shaw			2. Date of Dear Month プムル	Day	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and number) Season Hospice	Randa	or Location of Deat		4c. County of Balti	more
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday, 1 M 2 F 50) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Jan. 5	Year) 1.960	9. Birthplace (State or Foreign Country) Maryland
	aryland a-f show fied at	Director	Usual Residence of Decedent					10d. Inside City Limits
	vith the Ma 23a or 28 st be noti	ral Dire	10e. Street and Number 5016 Pimlico Road	10f. Zip Code 21215			10g. Citizen of Wh	·
99	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show er the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Y Never Married 2 Married 1 Y Never Married 2 Married	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Black,	- American Indian, White, etc.
21215-0036	72 hours at n "natural" tedical Exa	Completed	3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Dec (Specify only highest grade completed)	edent's Usual Occu e kind of work done DO NOT use retired	pation during most of wo	rking	16b. Kind of Bus	Black iness Industry
d 212	1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M	BB	Elementary/Seconday (0-12) College (1-4 or 5+) Car 1. Father's Name (First, Middle, Last)	Detail	er	me (First, Middle, I	Automok Maiden Surname)	oile
Maryland	iould be fi nd Mental marked imatic ev	잍	Andrew Shaw, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street		dy Brow		ite, Zip Code)
	1 and 2 should be filed vor Health and Mental Hygitem 27 is marked othe other traumatic event,		MacTrudy Austin/Mother 5016 20a. Method of Disposition 20b. Place of Disp	Pimlico	Road, B		e,Mary	land 21215 Dity or Town, State
Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or of		4 Donation 5 Other (Specify) Ardento	Crematio	n.Inc.7	-12-10	<u>Hanove</u>	r,Maryland l Chapel,p.A.
ä	De a m be	H	23a. Part 1. Enter the disease, or complicition ons that caused the death. Do not ex	<u>ouughari</u>	ora Roa	a, balti	more, ma	Approximate Interval Between
	Physician/ _ Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):					Onset and Death
1	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. ———————————————————————————————————					
10\$.	ate be executed ohysician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				<u> </u>	
68760	ertificate be ding physicii se as the bu	/Medic	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d Date	of delivery
P.O. Box 687	he death or y the atter iched for u	hysicia	in the past 12 months?	☐ Ectopic pregnar ☐ Other (specify) _	ncy		Mont	
ls, P.0	uires that t n signed b ıld be deta	ed by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause g	given in Part I.	23e. Did to		oute to the cause of death? B Probably 4 Unknown
Division of Vital Records,	he law req te has bee age 2 sho	Completed by Physician/Me				24a. Was a autop perfor 1 Yes	sy pr	ere autopsy findings available ior to completion of cause of eath? Yes 2 No
Eal	cian; T ertifica ector, p	Be C	25. Was case referred to medical examiner?		Place of Death (Che	eck only one)		2 2 1 2 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2
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0 0	th. : After e fune	cate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	woi	rk? ☐ Yes 2 ☐ No	20d. Describe III	ow injury occurred	
Divisio	tal or Atter rs after des al Director ed in by th	l Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		28f. Location (S City or Town		or Rural Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certifice within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or involved only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	estigation, in my opir e, death occurred at t	nion, death occurred the time, date and p	at the time, date and lace, and due to the	nd place, and due to cause(s) and man	to the cause(s) and manner stated. Iner as stated.
	V wit		29b. Signature and title of certifier MSRYWPAWL M'D		005746	5	7/8.	
	\		30. Name and address of person who completed cause of death (Item 23a) (Type N 5 Pajnpa KSE, M D 2835 SM		- 735 - 1	Baltimon	MD.	21209.
	Sta	te	31. Date then (Month, Day Year) 32. Registrary Signature	1				

DHMH 17 Rev 7/2009

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical Martha (rmc Sobus	2. Date of Death 3. Time of Death
	July 09 2010 2:54 A
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of	Death 4c. County of Death 170 Ward.
Howard County General Hospital Columbia 5. Social Security Number 6. Sex. 7. Age (In yrs. lest birthday) If Under 1 Year If Under 2	4 Hrs. 8. Date of Birth 9. Birthplace (State or Foreig
Director 023-30-4701 1 M 2 □ F 70 Yrs. Months Days Hours	Min. (Month, Day, Year) Country) Apr 4, 1940 Mass.
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
MD Howard Ellicott	t City 1 🗆 Yes 2 🗸 🗅 N
10a. State MD Howard Howard 10c. City, Town or Location Ellicott 10b. County Howard 10c. City, Town or Location Figure 10c. City Town or Location Figure 10c. City Town or Location Figure 10c. City Town or Location Figure 10c. City Town or Location Figure 10c. City Town or Location Figure 10c. City Town or Location Figure 10c. City Town or Location Figure 10c. City Town or Location Figure 10c. City Town or Location Figure 10c. City Town or Location Figure 10c. City Town or Lo	10g. Citizen of What Country? U.S.A.
The second state of Hispanic Origin 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin 14. Was Decedent of Hispanic Origin 15. Was Decedent of Hispanic Origin 15. Was Decedent of Hispanic Origin 15. Was Decedent of Hispanic Origin 15. Was Decedent of Hispanic Origin 15. Was Decedent of Hispanic Origin 15. Was Decedent of Hispanic Origin 15. Was Decedent of Hispanic Origin 15. Was Decedent 15. Was Decedent of Hispanic Origin 15. Was Decedent 15.	n? (Specify Yes or No- 14. Race - American Indian,
Armed Forces? If Yes, specify Cuban, Mexican, 1 Never Married 2 Married If Yes, Give 1 Yes 2 Mo If Yes, Give 1 Yes 2 Mo If Yes, Give 1 Yes 2 Mo If Yes, Give 1 Yes 2 Mo Specify:	Black, White, etc.
Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation	16b, Kind of Business Industry
The second and the se	
Registered Nur 17. Father's Name (First, Middle, Last) 18. Mother	's Name (First, Middle, Maiden Surname)
	Mary Burns
Jerome Sobus spouse 12142 Triadelphia Rd Fl	or Rural Route Number, City or Town, State, Zip Code)
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Memorial Gardens 21. Signature of Funeral Ser of 15 name 22. Name and Address of Facility Slack Funeral Hor	Jul 14, 2010 Marriottsville, Maryland
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	ne, P.A. a Pike Ellicott City, MD 21043
23a. Part 1. Enter the disease, or complications that based the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	ardiac or respiratory arrest, Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death) Medical Medical A Due to (or as a consequence of):	Onset and Death Years
Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	
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eq group in the second of the	
23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
So the state of death	
The law reduited that the death of the death	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow
Program is required to the control of the control o	24a. Was an 24b. Were autopsy findings available
ompl	autopsy performed? 1 \[\sqrt{yes} \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
The second secon	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Number of Death 28a. Date of injury 28b. Time of 28c. Injury at	sing Home 5 Residence 6 Other (Specify)
O b b b b c large of the large	28d. Describe how injury occurred
The part of the pa	28f. Location (Street and Number or Rural Route Number, City or Town, State)
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Li	4
Page 1 on the page of the page	urred at the time, date and place, and due to the cause(s) and manner sta
29c. License number	29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francis Wudian 1070 Charter Drive 3	2 Jul 09 2010
Francis Chudian 10700 Charter Prive 1	F310 Columbia MD 2104
State 31. Date filed (Month, Day or) 47 32. Registrate Gignature 9.	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#9nerFH, G905,7/30/2010, WS State of Maryland / Department of Health and Mental Hygiene 0 | 0 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SALAMONE Month Physician/ AM 2010 Medical 4a. Facility Name (if not institution, give street and number, C. County of Death, MONE 4b. City, Town, or Location of Death **Examiner** HOLLAND MANON ALF TOWSON 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral 1 M 2 X F Days Hours 9/41/ 73 19m 218-01-1972 92 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 X No BALTIMORE FORK 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 6405 BRINTON LANE 21051 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Xio
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 XWidowed 4 ☐ Divorced "natural" Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) 6TH GRADE College (1-4 or 5+) Mental Hygiene. SEAMTRESS CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNAVAILABLE VINCENZA be f JACK LUPPINO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6405 BRINTON LANE FORK, MD 21051 MARY ANN GALEANO/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot DULANTEY "VALLEY" MEM. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/13/2010 COCKEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MOO2 17 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21286 8521 LOCH RAVEN BLVD. TOWSON, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line and Death Immediate Cause (Final HYPOVOUE MIC Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examine のしひME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on MALNOU MIS ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Month 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death ☐ Yes ∠ . ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes PNEUMONIA 24a. Was an 24b. Were autopsy findings available autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate has prior to completion of cause of death? Yes 2 25. Was case referred to medical Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No . Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurrer Practionar To the best of my investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 705 FERWANDO DEL 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#17,18, perFH, G906, 8/5/2010, WS

State of Maryland / Department of Health and Mental Hygiens Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Sara Lee Semilia Month **Physician** July 8, 3:35 am /Medical 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Harve de Grace Harford Memorial Hospital | ft Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 1 / 1 2 / 1 9 4 4 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-42-2510 1 □ M 2 □ F 65 Yrs. Director Usual Residence of Decedent 10a. State MD 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ehov any Injury or other treumatic event, the Medical Examinar must be notified at once. Harford Aberdeen 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1013 Warwick Drive, Apt. 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 M Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Food Service Worker 17. Father's Name (First, Middle, Last Rogers Samuel R. Rogers 18. Mother's Name (First, Middle, Maiden Surname) Be Sara Lee Riffle ٩ Armena V. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sebastiano J. Semilia Jr./ 120 May Avenue, New Castle, DE 19720 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Final Journey Crem. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 7/10/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name of the first of the services 21203 21. Signature of Funeral Service Licensed Dorota Marshall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): Heart Failure /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ig physicien and as the burial-transit the deeth certificate be executed Due to (or as a consequence of): Physician/Medical ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) within 24 hours after death. To the Funeral Director: After this certificete has been signed by the completely filled in by the funeral director, page 2 should be deteched: Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. fnjury af Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö To the Hospitel of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) D 0063981 July 8, 2010 M.D. V 30. Name and address of person was simpleted cause of death (ftem 23a) (Type, Print) Benjamin Lee, M.D.
31. Date filed (Month, Day, Year) 669 Havre de Grace, MD 21078 Revolution St. M.D. 32. **Fig** State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ "DIAM SNYDER BERNICE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 11 Threw 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min. 097077 1922 87 Yrs. 214-12-2424 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No OWINGS MILLS BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21117 3410 ASSOCIATED WAY, #224 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No **M**aryland 21215-0036 Specify: If Yes, Give 3 X Widowed 4 Divorced WHITE Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RETAIL SALES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ POLANSKY FANNIE MAX 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BARBICAN WAY, BALTIMORE, MD 21208 ROCHELLE COHEN / DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Burial 2 ☐ Cremation 3 ☐ Removal from State PIKESVILLE, MD Donation 5 Other (Specify) DRUID RIDGE 07/13/2010 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Juneral Service Licenses REISTERSTOWN ROAD, PIKESVILLE, MD 21208 8900 23a. Part 1. Enter the disease, or co ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **€nysicia**n/ socach disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi) To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? rillat 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Wood 1 ☐ Yes 2 ♥No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **(N**o Certificate: To 1
☐ Inpatient 2
☐ ER/Outpatient 3
☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Alatural 5 \square Pending Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Ocertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

d

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 _ State	- '	artment of Health tificate of Death	_	2010	21923	
Registrar 1. Decedent's Name (First, Middle, Last)					uncate or Death	2. Date of De.	ileg. NOLL O 1 O		
	Physicia Medic		Ethel F. Tho	mpson		0 7 ^{lonth}	06 ^{Day} 2010 ^{ear}	3. Time of Death 10:11 AM	
	Examin	ier	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		4c. County of Death	n	
	-		Manor Care 5. Social Security Number 6. Sex 7. Aq	the same to a to be to be a to a	Baltimore		N/A	(0)	
	Funeral Director		220-22-4760 1 □ M 2X F	e (In yrs. last birthday) 86 Yrs.	Months Days Hours	Min. (Month, Da			
	no now	-	Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or Loc	eation			10d. Inside City Limits	
	arylar a-fsl fied	sct	MD N/A	-	imore			1 🏿 Yes 2 🗆 No	
2	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	Director	10e. Street and Number	Dare	10f, Zip Code		10g. Citizen of What Co		
7		Funeral	5300 Wayne Avenue		21207	,	U.S.A.	anu y 1	
98	after deat I", or iten xaminer r	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ If Yes, Give	No If	Vas Decedent of Hispanic C Yes, specify Cuban, Mexic ☐ Yes 2 🌠 No Specif	can, Puerto Rican, etc.)	14. Race - Amer Black, White Specify: D 1	, etc.	
ခု	atura cal E	Completed	Year or Dates.	163 Deced	ent's Usual Occupation		DI	ack	
15	72 h In "ni Media	ld u	(Specify only highest grade completed)	(Give k	ind of work done during mo NOT use retired)	ost of working	16b. Kind of Business I	naustry	
212	ygiene. ygiene. her tha		Elementary/Seconday (0-12) 12th Grade College (1-4 or 5		are Provid	ler	Self Empl	oyed	
Baltimore, Maryland 21215-0036	Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. anti-fi field and Mental Hygiene. anti-fi field z? is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Fred Bla	ke	18. Mot	ther's Name (First, Middle, 51e	Maiden Surname) Chandler		
ary			19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Num	ber or Rural Route Numbe	r, City or Town, State, Zip	Code)	
Σ .			Vanessa White (niece)		Wayne Ave	., Baltimo			
nore			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemetery, crem	sition (Name of latory or other place) L Cemetery	Date 7/12/2010	20c. Location - City or Baltimore		
Saltir	permit. Page 1 a Department of H Important: If ite any injury or oth		21. Signature of Funeral Service Licensee		i				
	<u>ਨੂਟ ਦਾ ਰ</u>		23a, Part 1. Enter the disease, or complications that caused		Name and Address of Faces of H. Br. 40 N. Fult				
PI	hysician/		shock, or heart failure. List only one cause on each line Immediate Cause (Final		Dement		1651,	Approximate Interval Between Onset and Death	
1	Medical Examiner		disease or condition resulting in death) a. Due to (or as a	a consequence of):	Devicent.				
		ner	Sequentially list conditions, if any leading to him ediate cause. Enter Underlying	roune countries (*)					
Citted		Examiner	Cause (Disease or iinjury that initiated events c						
certificate be executed	sician a	dical E	resulting in death) Last Due to (or as a	a consequence of):					
760 Gate b	phy.		d						
BOX 68	ttending or use a	Physician/M		2 Fetal death 3			23d. Date of deli Month	very Day Year	
7. 5	by the a	hysic	1 Yes 2 No 4 Pregnant at 9 Unknown	time of death 5 L	Other (specify)		Month		
S. Hat the	igned b	β	Part II. Other significant conditions contributing to death be	ut not resulting in the ur	nderlying cause given in Par		obacco use contribute to Yes 2 No 3 Pr		
	pluod	etec		, , , ,				opsy findings available	
DIVISION OT VITA! RECORDS, lal or Attending Physician: The law requires		Completed	-			24a. Was autor perfo	osy prior to c death?	ompletion of cause of	
	certifi ector	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		045	eath (Check only one)			
Phys •	this	2	1 ☐ Yes 2 ☑ NO 1 ☐ Inpatie 27. Manner of Death 28a. Date of injur	ent 2 ER/Outpatient y 28b. Time of	28c. Injury at	Nursing Home 5 Resid		<u>fy)</u>	
	After fune	cate	1 Natural 5 Pending (Month, Day 2 Accident Investigation		work? M 1 ☐ Yes 2 [ow injury occurred		
/ISIO	rer dea rector: by the	Certificate:	3 Suicide 6 Could not be	ry - At home, farm, stre . (Specify)			Street and Number or Run	al Route Number,	
o lejia	ours af ours af leral Di filled ir		29a. Certifier 1 Certifying Physician: To the best of		ocured at the time date and			ed	
the Hos	the Fur	Medical	(Check 2 Medical Examiner: On the basis of exonly one) 3 Certifying Nurse Practioner: To the I	camination and/or investi	gation, in my opinion, death eath occurred at the time, da	occurred at the time, date a ate and place, and due to the	nd place, and due to the c e cause(s) and manner as	ause(s) and manner stated. stated.	
2	vit.		29b, Signature and title of certifier	MD	29c. License number		29d. Date signed (Month,	Day, Year)	
g),		30. Name and address of person who completed cause of de			such Rd Pan	Willo Mis	21276.	
C				\$813 Wa	Afram Wo	שום דים למי	12111	41674	
	Stat Registra		JUL 142010 Lev	un f. A	rand				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:15 AM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PARKWAY \$60 bruk REDCLICK f Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 25-26-7723 1 M 2 F Days Months Min. 8 Yrs. MO Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is the flocial experience must be notified at mo ALLOCRUR 1 Yes 2 No Funeral Director Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 1401 ()5 A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: BLACK Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Home College (1-4or 5+) UME MAKER 10 14 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FOREMAN ည 19a. Informant's Name/Relationship (Type, Print) [19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State tBENERER CH. Com. July 9, 2010 1JAMSVUL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice see sund. rolles 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Candisdagealan ATheroscleronc **Physician** 74.711 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a year go to infine fall cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecutivo e of: attending physician and for use as the burial-transit Examin Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No ed by the detached 9 Unknown cate has been signed , page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy Hospital or Attending Physician: The performed certificate 1 ☐ Yes 2 D No Division of Vital 2 🗆 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending n 24 hours after death.

Re Funeral Director: A pletely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO035152 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month

Year)

32. Reastrar's

10-05047 Ronald Taylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 3 Time of Death Month D July 5, 2010 Ronald **Medical Examiner** Taylor 2020 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Harbor Hospital Center **Baltimore** 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) WV 214-46-0291 Months Days Hours Min. Director 63 4-16-1947 1 XM 2 F Yrs Usual Residence of Decedent any 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore County Halethorpe 1 X Yes 2 No or items 23a or 28a-f show death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Annapolis Road, Apt. A 21227 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 X Married White, etc. Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after d
Department of Health and Mental Pfygiene
Importants: If item 27 is marked other than "natural", or
injury or other trannatic event, the Medical Examiner. 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Apartment Rental Maintenance Supervisor 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Edmond Eli Taylor Sarah Frances Imogene Bradford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda L. Taylor / wife 3801 Annapolis Rd. Apt A Halethorpe MD 21227 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 XX urial 2 Cremation 3 Removal from State Glen Haven Mem. Prk. 7/10/10 Glen Burnie MD Donation 6 Other Specify 22 Name and Address of Facility Kirkley-Ruddick Funeral Home 21. Signature of Funeral Ser M01364 421 Crain Hwy SE Glen Burnie MD 21061 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and /Medical Death Immediate Cause (Final disease Atherosclerotic cardiovascular disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and trans. sician/Medical X UNPENDED AMENDED, 27, per ME g905 7/15/10 TT Box 68760, attending phys for use as the bu IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) requires that the death 1 Yes 2 No 9 Unknown 9 Unknown Phy Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? 1 ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other DOA this 1 🗸 Yes ို After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 24 hours after death. To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 6, 2010 arde 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Carol Allan, MD 111 Penn Street, Baltimore, MD 21201

State Registra

32. Register's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3010 PM Bertha Elizabeth Tucker Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Nursing Grace tizen's Tavre 8. Date of Birth
Oct 9, 1908 9. Birthplace (State or Foreign Country) Maryland Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. Funeral 1 M 2 XF Min. Hours Director 101 219-16-8085 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21.001 5 Poplar Grove Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Phone Company Telephone Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William E. Chaney Matilda Raith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Poplar Grove Avenue Aberdeen, Maryland 21001 Luella Tucker, Daughte<u>r In La</u>w 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) John's Cemetery 07/15/10 St. Ellicott City, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility
MacNabb Funeral Home, P.A.
301 Frederick Road Catonsville, Thomas Gregor Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease Grow 94 Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 No Month Day Year n signed by the a g Unknown UCKEY (SECTMO Division of Vital Records, P.O.) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 010 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown No the troops...

To the Funeral Director After this certificate has been signatured filled in by the funeral director, page 2 should 1 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 1 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical VCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 132609 13/10 Wilmoun MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Milham 13 +1DG NW 21078 enolution st 11111 32. Regis 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month eviana 9:27 PM 2010 Medical 4a. Facility Name (if not institution, give street and num **Examiner** 4b. City, Town, or Location of Death 4c. County of Death rgity of Maryland Medical Cenk mou 7. Age (In yrs. last birthday) If Unde **Funeral** If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Min O(Month 1 8y, Yef) 938 **Director** Usual Residence of Dec permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director timore MD 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral hnsv vania 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ģ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates. Specify. 3 Widowed 4 Divorced Completed Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired day (0-12) College (1-4 or 5+) ectrica 0 Be 18. Mother's Middle, Mai 2 (Street and Number or Rural 3651 b. Place of Disposition (Name of cemetery, cremetaly or other 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 🗌 Other (Specify) re of Fundral Service Licens 21, Sighal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) umonia Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? After this certificate has been signed by the atte funeral director, page 2 should be detached for 5 Other (specify) Month Dav Year 1 Yes 2 9 Unknown 2 \square No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pendina after death. Director, Af 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a

To the Funeral D Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) e and title of 29b. Signati

DHMH 17 Rev 7/2009

State Registrar Bulhmore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parker

Samuel Temple	: Wł	State of Maryland / Department of Health and Mental H 1-For State Certificate of Death		2010 2010	21928	
Physici	an/	Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Dea	eg. No. th	3. Time of Death	
Medical Exam			Month July 8, 20	Day Year	0450 hrs	
**		4a. Facility Name (if not institution, give street and number) 321 E. Lanvale Street Apt. A 4b. City, Town, or Location of Death Baltimore		4c. County of Death		
Euperal		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s. 8 Date of Bir	rth (MM/DD/YYYY) 9. Bird	hplace (State or	
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,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
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Maryland 28a-f show any d at once.	ţċ	Maryland Baltimore 10e. Street and Number 10f. Zip Code	14	0g. Citizen of What Cour	77	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Director	321 East Landvale Street, Apt. A 21202		U.S.A.	u y ·	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	Samuel Temple Whitfield, Sr. Pinnie				
213 buld b Men marl	ToE	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I	Rural Route Nun	nber, City or Town, State,	Zip Code)	
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re, l and l'Heal fiter fiter		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State	
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Baltimo permit. Page Department of Important:		T. T		Funeral		
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Division To the Hospital or Attency within 24 hours after death To the Funeral Director:	Š	4 Homicide determined (Specify) 29a. Certifier Count in Physics Table 195	1			
he Ho in 24 he Fu pletely	cal	Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a				
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier 29c, License number	,	29d. Date signed (Mon		
	-	O.C.M.E.		July 8, 2010	, , , , , , , , , , , , , , , , , , , ,	
d	ŀ	30. Name and address of person who completed eause of death (Item 23a)		101111		
V		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	01			
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regist	rar	JUL 1 4 2010 Burn A. Sant				

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OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 10f per fh g905 7-14-10
State of Maryland / Department of Health and Mental Hygiene 2010 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year ENTAMIN MILLIAMS July 10-15 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARE MT (MORE HVTURE SANDTUM sprim Social Security Number If Unde Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Min 1**X** M 2 □ F 1/27/25/1924 85 055-22-0538 MD Director Usual Residence of Decedent 23a or 28a-f show I Hygiene.
I other than "natural", or items 23a or 200.

4. Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1100 N. Gilmore Street 21217 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Yes 2X No Specify: Specify Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Attendant Race Track other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marie Benjamin Williams Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Wade(sister) 2827 Clifton Ave., Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 07/09/10 Zion Cem. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Josephades of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licensee PA 21217 which N. U filliamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ENILIT disease or condition resulting in death) Medical Examiner ARTERT CORONAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? MA 2 🗆 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signatu 29d. Date signed (Month, Day, Year) e and title of certifier D003294 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34 BALIMANE Tans mos A surt 31. Date filed (Month, Day, Year) monny 2125 300 32. Revistrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

		_	For	State of I	Marylan					nd M	ental Hyg	iene		
			State Registrar			Cer	tificate	of De	ath		F	eg. No.	2010	21930
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	Medic			NITE							Month J G L	12	2010	12:35AM
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	Funeral Director			^O M 2 X F /./	58	ast birthday) Yrs.				Min.	8. Date of Birth Month Day 7-22-1	Year)		thplace (State or Foreign untry) MD
			Usual Residence of Decedent		50						7-22-1	771		FID
	land shov dat	tor	10a. State 10b. County		10c. Cit	y, Town or Loc	ation							10d. Inside City Limits
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	deat riten nerr	Fu	11. Marital Status	12. Was Deceder Armed Forces	?	5. 13. V	Vas Deceden Yes, specify	t of Hispa Cuban, N	anic Origin Mexican, F	? (Spec Puerto R	fy Yes or No- ican, etc.)	14	Race - Ame	
36	within 72 hours after death with the Maryland gjene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give		1	☐ Yes 2 5	X No S	Specify:			Sp	pecify:	White
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Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. **Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)					18	8. Mother's	s Name	First, Middle, N	Aaiden Su	rname)	
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	and 2 Healt tem 2 Ither		Sidney J. Waite 20a. Method of Disposition	Husband	20h B	1 963 S Place of Dispos			nor R		Reist		own,M ation - City or	D 21136
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Baltimore,	permit. Page Department Important: I any injury o once.	1 8	4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Licens		Lake	e View				7/15	/10 24 Reis			, Maryland
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189	certifi nding us e a	ın/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregna	ncy	1 =					23	d. Date of de	livery
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-	ithin (Ň	only one) 3 Certifying Nurs 29b. Signature and title of certifier	se Practioner: To the	ne best of my	/ knowledge, d		d at the tir		nd place,			ind manner as signed (Month	
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•	9		30. Name and address of person who	completed cause of	death (Item	23a) (Tivne D			-			500	1 12	2013
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			1 - For State Registrar	State of Ma	-	epartment of F Dertificate of		Mental Hy		2010	21931
			Decedent's Name (First, Middle, L.)	ast)	,			2. Date of De	eath		3. Time of Death
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	Director		217-83-0522 Usual Residence of Decedent		1 "	o.	<u> </u>	11-30	J-20	00	MD
	Maryland a-f show	tor	10a. State 10b. County MD	na	10c. City, Town o						10d. Inside City Limits 1 Yes 2 No
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	23a c	ral	2115 Pentland	Drive		2]	L234		U	S A	
215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Item Wordson Evan, item 11 into the notified at	by Funeral Director	11. Marital Status ↑ Never Married 2	12. Was Decedent I Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Xi} \) If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - Ame Black, White Specify: B	
5-("natu	lete	15. Decedent's E (Specify only highest g.	Education rade completed)	1 (0	ecedent's Usual Occup Give kind of work done	during most of wor	^{rking} na	16b. Kir	nd of Business/l	ndustry na
2121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5		fe. DO NOT use retired	ot)				
	filed I Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Las		ııa		18. Mother's Nar	me (First, Middle	, Maiden	Surname)	
Maryland	Aenta Aenta rked tic ev	To B	George Wees	5			Angela	a Ford			
ary	shou and A is ma		19a. Informant's Name/Relationship	(Type. Print)	19b. N	lailing Address (Street	and Number or Ri	ural Route Numb	er, City or	r Town, State, Z	Zip Code)
	and 2 ealth n 27	ļ., ,	Angela Wees-Mo	other		115 Pentl		ive Ba		, MD 2	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natuu any injury or other traumatic event, It. W. dical. once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 [☐Removal from State	20b. Place of D cemetery,	isposition (Name of crematory or other plac	ce)	Date	20c. Lo	cation - City or	Town, State
單	permit. Page Department o Important: If any injury or once.		4 Donation 5 □Other (Spec		King	Memorial 22. Name and Addre	Pk 7-14	1-2010	Rai	ndalls	town, MD
Ba	permi Depa Impo any is		21. Signature of Funeral Service Lice	K. Jme		1101 E.	North		e Ba	alto,M	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications at caused one cause on each lir	the death. Do no	enter the mode of dyin	ng, such as cardia	c or respiratory a	arrest,	1	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a/	neumo	nia					5 days
7	/Medical Examiner		1	Due to (or as	a consequence of	/-	11	2			12. 11-
		ē	Sequentially list conditions, if any, leaving to immediate	b. Due to (or as	CONTRACTOR OF	spira tory	Failure				13 months
	cuted nd ansit	Examiner	Sequentially list conditions, if any, leauning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c Chi	mile	una dis	east_				13 months
oʻ	icate be executed physician and the burial-transit	Ex	resulting in death) Last	Due to (or as	a consequence of)	3	<i>l</i>				
38760,	ate b hysic the bu	dical		_d	no plastic	left He	art				BIRth
w	ertific ding p	Mec	IF FEMALE:		,						
P.O. Box	The law requires that the death certifite has been signed by the attending age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	ey .		2	23d. Date of del Month	ivery Day Year
	s that gned t	by PI	Part II. Other significant conditions	contributing to death bu	it not resulting in th	ne underlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ğ	w requires been sign should be	edk						1 🗆	Yes 2	No 3□ Pr	obably 4 🗌 Unknown
of Vital Records,		Completed						24a. Was auto perfo 1 ∐Yes		prior to death?	topsy findings available completion of cause of
/ita	Physiclan: T this certificat al director, pa	Be (25. Was case referred to medical examiner?			l au	26. Place of Dea	ath (Check only			
of	di is	၉	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		atient 3 DOA Oth	4 LI Nursing F	dome 5 ☐ Res			cify)
o	ding h. After funer	tion	1. Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	, Year) 200. IIII	ry Wor	ryat k? Yes 2.⊟No	28d. Describe	now injury	y occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	oe Diago of Inju	ry - At home, farm : (Specify)	, street, factory, office	100 22.10	28f. Location (City or To	(Street and wn, State)	d Number or Ru)	ıral Route Number,
	ne Hospital n 24 hours a ne Funeral I pletely filled	edical (29a. Certifier Check only one) Certifying P	hysician: To the best of miner: On the basis of and manner sta	examination and/	or investigation, in my o	ppinion, death occi	urred at the time	, date and	place, and due	to the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	1		29c. Licens	e number		29d. Date	e signed (Monti	h, Day, Year)
	200		Linds Kyle U	alter M	0	10003	6833		Juli	, 82	2010
	41		30. Name and address # person who	completed cause of de	eath (Item 23a) (Ty	pe, Print)	4 1	r 4 /	anice)	44 4	10 +
	- 61	to	Linda Fyle Wall 31. Date filed (Morth, Day, Year)	32, Registra	Tediatric r's Signature	pe, Print) LLU, UNI	versity o	A Maryla	ind /	Medical	Caler
	Sta Registr		111 1 4 2010	Mary de la	bore	1					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #30 per DVR 9905 7/14/10 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Terry Lee Zellmer Month 11:27 a M Jul 802010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Howard** 4b. City, Town, or Location of Death Examiner Elkridge 6320 Meadowridge Road 24 Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 57 (Month Day, Year) 2 MD 214-64-8935 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location Director **Elkridge** MD Howard 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21075 6320 Meadowridge Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black. White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) **County Government** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shirley Mellor ပ unknown 19a. Informant's Name/Relationship (Type, Print)
Harry Zellmer Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6320 Meadowridge Rd. Elkridge, MD 21075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place.
Atlantic Crematory, LLC Jul 09, 2010 Glen Burnie, MD Ponation 5 Other (Spenity) 22. Name Stack Parer ar Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 ture of F, eral Service Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final concer -metastatic to liver Physician/ Colon Medical esulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the the Hospital or Attending Physician: The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð encephalopathy Records, 1 🗌 Yes 2 L No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Animiz autopsy performed 1 Yes 2 No Yes 2 No of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: မ 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Division Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Example 1 (a) The best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0305 7-9-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jon Kent Minford, MD 10710 Chapter Dr, Suite CO2O, Columbia, MD 21044 10 31. Date filed (Month, De 32. Rajistrar's Signature State Registrar

DHMH 17 Rev 7/2009

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			1 - State of Maryland / Dep	artment of F		, 0	iene eg. No 2010	21933
			Decedent's Name (First, Middle, Last)		- Cat.	2. Date of Deatl	h	3. Time of Death
	Physicia Medic		Tatyana Zykina			July 8	o, Day 2010 ear	2:30pm M
	Examir		4a. Facility Name (if not institution, give street and number)		or Location of Death		4c. County of Death	
			1 Clear Skys Ct. STE T-1	Pikes			Baltir	nore
	Funeral Director	ш	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 X F 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1–16–19	Year) 9. Birth Court 21 Ukra	place (State or Foreign ntry)
			Usual Residence of Decedent			1-16-19	ZI TUKTA	iine
	f sho	į	10a. State 10b. County 10c. City, Town or Lo	cation				10d. Inside City Limits
	Man 28a- notifie	Funeral Director	MD Baltimore Pikesvi					1 ☐ Yes 2 🛣 No
	th the	la La	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What Cou	ntry?
	ath w	nue	1 Clear Skys Ct. STE T-1 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of H		ocify Ves or No-	Ukraine 14. Race - Ameri	an Indian
9	or it	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ♣ No		lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White,	
903	urs af ural", al Exa	ted	Year or Dates.	1 ☐ Yes 2X☐ No	Specify:		Specify:	White
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/lar	d be f Menta arked	욘	Zahar Fantankin		Pelagey	а	(ι	ınknown)
Maryland 21215-0036	shoul and l is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ng Address (Street	and Number or Rura	l Route Number, (City or Town, State, Zip	Code)
e)	and 2 Health em 27 ther to							le,MD 21030
JOL	nt of I		1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, cre	matory or other place	ce)		20c. Location - City or T	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) All Saint 21. Significate of Funeral Service Licensee	2. Name and Addres	-		Reisterstov	m, MD
B	permir Depar Impor any in				1111	INE FUNE Rd. Reis	RAL HOME terstown, N	ID 21136
			28a. Part 1. Efter the disease, or complications that caused the death. Do not ent					Approximate Interval Between
7	hysician/			15062	T		-	Onset and Death
10	Medical Examiner		resulting in death) Due to (or as a consequence of):			· ·		
		er	Sequentially list conditions, b b	0/5	in to	CTIO	<i>\(\gamma\)</i>	
0.	ted 1 Insit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	itus	c Cus	10105	was color	
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387	eath certifical attending ph I for use as th	/Me	IF FEMALE: 23b Mas decedent program 23c. If yes, outcome of pregnancy					
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P.O.	ires that the dea		Part II. Other significant conditions contributing to death but not resulting in the	ınderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
ds,	/ requires been sig should b	ted	Hibranion			1 ☐ Ye	s 2 1 Ho 3 Pro	bably 4 🗆 Unknown
202	aw rei as be 2 sho	Completed by	Hypolipidemia			24a. Was an autopsy	prior to co	psy findings available impletion of cause of
Re	hysician: The law his certificate has I director, page 2 s	Con				perform	ed? death?	2 🗆 No
ita	sician: The certificate I irector, pag	Be	25. Was case referred to medical examiner?	Othe	ace of Death (Check	only one)	_	
<u>\$</u>	Phys r this eral dii	e: To	1	nt 3 🗆 DOA	4 U Nursing Ho	me 5 Resider 28d. Describe hov	nce 6 Other (Specify)
on C	nding ath. r: Afte e fune	icat	1 → Matural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	f 28c. Injury work M 1 \Box	(? Yes 2 □ No	Edd. Doddings nov	v injury occurred	
Division of Vital Records,	r Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura	Route Number,
Ö	ital ol urs aft ral Di							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Ahours after death. The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death	tigation, in my opinic	on, death occurred at	the time, date and	I place, and due to the ca	use(s) and manner stated.
	Fo the within Fo the complex c	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	29c. License			ause(s) and manner as si Id. Date signed (Month,	
	0		Mell R Kronach.	D WY	14753-	MO	7/9/	110
•	2		30. Name and address of person was completed cause of death (item 23a) (Type,	Print)		11/	11	1 1
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	34106	300,	rire)	ville 1	10gha
	Stat Registra		31. Date filed (Month, Day, Year) 32. Register's Signifure		•			, –

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25, Day 2010 ar Physician/ June 7:31P м Madeline Patricia Alliegro Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ocean City Worcester 10110 Bonita Drive If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** prin Day Year) 1924 Country) NY 1 □ M 2 🖾 F Hours Director 127-16-9703 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10110 Bonita Drive 21842 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: white Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Educational System Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Carlyle Harry Brannigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10110 Bonita Drive Ocean City, MD 21842 Marilyn A. Weber- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
ape Henlopen Crem 6-28-10 1 Burial 2 Tremation 3 Removal from State Cape Frankford, DE 4 Donation 5 Other (Specify) 21. Signate of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final erelesvasculan Voce, of Physiciai*u* disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Securitally list over this ex-Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) signed by the aid be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 Yes Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has become director bage 2. autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 Yes 2 No 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 □ only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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JUN 29

phia Ave. Ocean Cty, mo 21842

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JUNE 7:45 A M 26 2010 ELEANOR BRADUNAS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE SACRED HEART NURSING HOME HYATTSVILLE GEORGE'S 8. Date of Birth (Month, Day, Year) 02/14/1926 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🗹 F Hours 84 Director 046-22-2748 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ⊈Yes 2 □ No PRINCE GEORGE'S HYATTSVILLE MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5805 QUEENS CHAPEL ROAD 20782 IISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: ģ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than CLOTHING SALES 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is marked WILLIAM BRADUNAS MARY ANDREWSCABICH 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 96, BARNESVILLE, MD 20838 DOUG STEIN/NEPHEW-IN-LAW t of Health 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State STAUFFER CREMATORY 6/28/2010 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Suneral Service Licensee HILTON FUNERAL HOME P.O. BOX 86, BARNES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END STAGE DEMENTIA YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lister underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2: autopsy perform certificate 1∐ Yes 2 9 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Division or Attending 1 Natural 5 Pending investigation death, 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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ANDRES SALAZAR,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

3621

's Signature

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32. Registrati

D51051

LIGON RD., ELLICOTT CITY, MD

JUNE 28,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 1:10P M June Sue Elizabeth Byers /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Mennonite Fellowship Home Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, You 12, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2/□ F Nov. 1913 Pennsylvania Director 175-03-2027 96 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertal Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Hagerstown Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21740 12349 Huyett Lane Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [**X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stanley Co. Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katy I. Meyers John C. Byers ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nora Pugh - sister 2803 Maclays Mill Road, shippensburg, PA 17257 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Meyers Cemetery 6/29/2010 Welsh run, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MOIYIY J.L.DAvis F.H., 12525 Bradbury Ave., Smithsburg MD JU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 12piration Physician Pherimonia /Medical Due to (or as a cons + uence of): Examiner Sequentially list conditions. is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to (of as a consequence Examine certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No certificate I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Rent h ma Hospital: 1 🔲 Yes 200 P 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 🗌 Yes 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

To the Hospital or Attending |
within 24 hours after death. completely filled in by the

State

29b. Signature

Registrar

DHMH 17 Rev 1/2001

Mahmood Shahid 31. Date filed (Month, Day, Year) JUN 2 8 2010

580C Northern Ave Hagerstown MD 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Darke

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	1aryland		tment of F ificate of D	lealth and I Death	Mental Hy	giene Reg. No.	110	2193	7
	Physicia	an/	1. Decedent's Name (First, Middle,	,					2. Date of De		Year	3. Time of Death	
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	Funeral Director		5. Social Security Number 240 44 0638	. Sex 7. A 1x	ge (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept		9. Birth	place (State or Foreigntry) Th Carol	ign Lina
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12	20		30. Name and address of person who	completed cause of d	eath (Item 23	a) (Type, Prin	1))	7	f. ·	. (2)	11		, ,
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DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JUN 3 0 2010

32/Registrar's Signature

10-04944 Johnathan Cusick Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	SICK	1- For State Registrar State of Maryland / Department of Health and Mental Hyglene Certificate of Death Reg. No.	939
Physic Medical Exar		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
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b, MD 21215-0036 and 2 should be fited within 72 hours after death with the Maryland teath and Mental Hygiene. rem 27 is marked other than "matural", or items 23a or 28a-f shortraumatic event, the Medical Examiner must be notified at once	Director	106. Street and Number 107. Zip Code 109. Citizen of What Country?	
eath wit items 2 ust be n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc.	Black,
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Baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 420 H S T. O. B. K. HENRY FUNERAL HOME WOSH, D.C. 26	E- 0002
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approxim	nate Interval
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6876 certificat iding ph	ician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Tenural Director. After this certificate has been signed by the attending physician and appletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physic	1 Yes 2 No 9 Unknown 9 Unknown	
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To To Cor	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yea	r)
		Caroe Hallan O.C.M.E. July 2, 2010	
Ø		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
St Regist	ate	0000 40 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2010 Physician/ JUNE EDITH REGINA THOMAS DUNNINGTON 8:10 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4010 DUNNINGTON THOMAS PLACE MARBURY CHARLES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Months Days Hours Min MARYLAND 82 NOVEMBER 6. Director 213-32-2999 1928 Usual Residence of Decedent f show 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Ħ Director notified 1 X Yes 2 No 28a-f MD CHARLES MARBURY 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 4010 DUNNINGTON THOMAS PLACE 20658 UNITED STATES items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: BLACK "natural", 3 Widowed 4 Divorced Completed Year or Dates er than "natur the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 FEDERAL GOVERNMENT EXPLOSIVE TECHNICIAN of Health and Mental Hygie item 27 is marked other other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FRANK THOMAS MINNIE ELLEN LEE THOMAS BROOKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAMELA N. DORSEY/DAUGHTER 4010 DUNNINGTON THOMAS PLACE, MARBURY, MD 20658 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of 1
Important: If it 1 X Burial 2 Cremation 3 Removal from State PLEASANT GROVE CHURCH CEM. JULY 1, 2010 MARBURY, MARYLAND 4 Donation 5 Other (Specify) skinature of Fuperal Action I e THORNTON FUNERAL HOME, PA 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 IADIA C. THORNTON JOHNSON/MO0583 23a. Part 1. Enter the disease, or complication the mode of dying, such as cardiac or respiratory arrest, a that caused the death o not en Approximate Interval Between Onset and Death shock, or heart failure. List only one ca n each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 No detached 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 K Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗆 No s after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature ar

30. Name and

31. Date filed (Mont)

certi

30

2010

John

d cause of death (Item 23a) (Type, Print)

Patterson

Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Surratte Rd. Suite 2014 Clinton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#5perfuneral home 7/1/10 confidence of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 9:45 PM Marie ivian Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethese Hu. rhan Birthplace State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, 1 □ M 2 🔀 F Months 30-1605 70 Director Vrs PU Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hemione Director 1 Yes 2 No Rockulle Maryland Monte 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral UGA 20852 042 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give DUPUY (VIVIAN 6125) 0 (4) 45 pm Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) (Fovernment recleral 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 J 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10702 DIDIA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 2-10 4 ☐ Donation 5 ☐ Other (Specify) Marzyl Signature of Funeral Service Licenses 22. Name and Address of Facility Heres 20608 1589 Great 23a. Part 1. Enter the diffease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Immediate Cause (Final Onset and Death Physician/ well disease or condition resulting in death) AKY Medical Due to (or as a conse mence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 Yes 2 2 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 1 No prior to completion of cause of death? 1 ☐ Yes 2. No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. onty one) To the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) d address of person who completed cause of death (Item 23a) (Type, Print) 31. Date iled (Month, Day Year) State **JUN 30** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2040PM **GLENN** DAVIS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico CEME 301/36UKU TENINSULA REGIONAL If Under 1 Year If Under 24 Hrs Social Security Number **Funeral** Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 | F Months Min. Hours JAN 17, 1947 63 MILFORD, DE Director 222-32-2594 Usual Residence of Decedent show 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director or 28a-f 1 🗌 Yes 2 😿 No DELAWARE SUSSEX **MILLSBORO** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a Funeral 28213 WALT CARMEAN LANE 19966 USA or items 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? þ 1 Never Married 2 X Married Yes 2 No Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: WHITE "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) MACHINE OPERATOR NYLON MANUFACTURING Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic evea once. 2 CHARLES E . DAVIS PHYLLIS SHULTIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY R. DAVIS / WIFE 28213 WALT CARMEAN LANE, MILLSBORO, DE 19966 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State MILLSBORO CEMETERY 6/29/2010 MILLSBORO, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature uneral Service Lice Name and Address of Facility
WATSON FUNERAL HOME
211 WASHINGTON ST, MILLSBORO, DE 19966 MO136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician STENOSLI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) YLMONARY or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown ğ been signed be should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perforr certificate l within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 - ER/Outpatient 3 - DOA Certificate: 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1
Yes 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatui 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31 Date filed (Month, Day, Year)

2

23

12010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jean Frances Dodson 23, Day 2010 Pear 1:55P. 当代的 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard 10924 Hillcrest Drive Laurel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 218-30-2938 1 🗆 M 2 😾 F 76 March 23 Yell 934 Maryland **Director** Usual Residence of Decedent than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Howard Laurel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10924 Hillcrest Drive 20723 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 Yes 2 XNo
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (012) College (1-4 or 5+) Television Survey Editor Arbitron Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Herbert Murray Boswell Margaret Mary Crounse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other tra Benjamin Lee Dodson -husband 10924 Hillcrest Drive Laurel, Maryland 20723 20a. Method of Disposition
1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metropolitan Crematory 6/28/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Donald W. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, MD 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death 22 days Physician/ Osteomyelitis Medical Due to (or as a consequence of): Examiner Gangrene - Left Foot 22 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin attending physician and for use as the burial-transit Diabetes Mellitus years Due to (or as a consequence of) Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month signed by the a 9 Unknown art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Senile Dementia To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No injury Investigation 6 Could not be ☐ Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) Cynthia M. Delleams, D.O. D33299 June 25, 2010

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Cynthia M. Williams, DO 3720 Upton Street, N.W. Washington, DC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	of Marylan		artment of H			iene 2010	21944
			Decedent's Name (First, Middle,	Last)	-				2. Date of Deat	h	3. Time of Death
	Physicia Medic		Ruth Frankenbe	rg					June 24	4, 2010 Year	12:15 A ^M
	Examin	er	4a. Facility Name (if not institution,		,		4b. City, Town, or		1	4c. County of Deat	
			Hebrew Home of 5. Social Security Number				Rockv	ille If Under 24 Hrs.	O Date of Disth	Montgon	
	Funeral Director		101–03–2318	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. Ia 94	Yrs.	Months Days	Hours Min.	 8. Date of Birth (Month, Day,	Year) 1915 Ne	thplace (State or Foreign untry) EW Jersey
			Usual Residence of Decedent		24				J July I		
M	/land f sho ed at	ţor	10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	28a-	ire		omery	R	lockvil					1 ¥ Yes 2 □ No
	th the 3a or the r	al	10e. Street and Number				10f. Zip Code	00050	1	10g. Citizen of What Co	
	ath wi	Funeral Director	6121 Montrose F		edent Ever in U.S	13 \	Vas Decedent of Hi	20852	necify Yes or No-	14. Race - Ame	JSA
ဖ	er de or ite minei	by F	1 Never Married 2 Marr	Armed Fo	rces?		Vas Decedent of Hi f Yes, specify Cubar		o Rican, etc.)	Black, White	
Š	ırs aft ural", IExal	pa	3 XWidowed 4 Divorced	If Yes, Giv Year or Da		1	☐ Yes 2 🛣 No	Specify:		Specify:	White
2-("2 hou "nati	Completed	15. Deceden (Specify only higher	t's Education st grade completed,		(Give i	lent's Usual Occupa kind of work done d	ation uring most of wor	king	16b. Kind of Business	Industry
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р Б	led wi Hygir other ent, t	Be (17. Father's Name (First, Middle, L	_L ast)		п	memaker	18. Mother's Nar	ne (First, Middle, N		WII HOME
lan I	l be fil lental rked tic ev	욘	Max Applebaum						Soskin		
ary	thould and N is ma		19a. Informant's Name/Relationsh			19b. Mailir	g Address (Street a	nd Number or Ru	ral Route Number,	City or Town, State, Zip	_{o Code)} # 204
Σ	nd 2 s ealth m 27 er tra		Richard Singer	Son		212	Califor	nia Stre	et, NW,	washington	, DC 20000
Baltimore, Maryland 21215-0036	pe 1 au t of H Mrite or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 Sr Removal from		emetery, cren	sition (Name of natory or other plac		Date	20c. Location - City or	of New Jersey
<u>=</u>	t. Pag tmen tant: jury		1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (S				Cemetery				
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	5 9	21. Signature of Euneral Service Li	Melissa	1597 Greenhu			_		al Direction ille, Mary	
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that	caused the death	n. Do not ente	er the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between
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	Medical Examiner		resulting in death)	Due to	(or as a consequ	ence of	e Der S oli				
		<u>ا</u> و	Sequentially list conditions,	b. 10	MUIN	son	S ou	sease			
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	xecur n and al-trar	Exa	that initiated events resulting in death) Last	c. Due to	(or as a consequ	ence of):					
09	or artenang Prysician: The law requires that the death certificate be executed that death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	dical		d							
6876	ng phy as th	Med	IF FEMALE:								
و ×	requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	come of pregnar Birth 2 🗆 Feta	l death 3 🗌	Ectopic pregnanc	y		23d. Date of de Month	
Вох	the at	ysic	1 Yes 2 No 9 Unknown	4 ☐ Preg 9 ☐ Unki	nant at time of d nown	eath 5 ∟	Other (specify)			Worth	Day Year
P.O.	nat the ed by detacl	Ph.	Part II. Other significant conditio	ns contributing to d	eath but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
S, F	signe d be	d by							1 □ Ye	es 2 No 3 P	robably 4 🖾 Unknown
ord	requisition shoul	Completed							24a. Was ar		topsy findings available
Division of Vital Records,	sician: The law incertificate has be irector, page 2 s	l l							autops perforr 1 \sum Yes	med? death?	completion of cause of
<u>a</u>	an: I rtifica ttor, p	Be C	25. Was case referred to medical			- 11	26. Pla	ace of Death (Che		Z LAX NOT	3 22 110
=	nysician: his certific I director,	70 E	examiner?	Hospital:	Inpatient 2		nt 3 🗆 DOA Othe	r: 4 Nursing H	lome 5 🗆 Reside	ence 6 Other (Spec	cify)
10	ing P	ate:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date (Mon	of injury th, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe ho	w injury occurred	
101	trend death tor: A	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r	not be	of Inlune At ho	ma form atr		Yes 2 No	OOA Laanting (OA	and Mumber of Di	and Payeta Mumbar
	after after Direc	Cer	4 Homicide determi		ng, etc. (Specify)		eet, factory, office		City or Town	reet and Number or Ru ı, State)	rai noute rvuilibei,
△	no tre hospital or Atending Pny, within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical								se(s) and manner as sta	
3	ne ne in 24 he Fu iplete	Mec								d place, and due to the cause(s) and manner as	cause(s) and manner stated.
	North Con		29b. Signature and title of certifier	111	2 015		29c. License			9d. Date signed (Monti	
	12		- yeu	000	MI			9568	•	6/24/	10
			30. Name and address of person v Atchuth Geetha	who completed caus C. Chila	kamarri	. M.D.	2150 Pen	nsylvani	a Ave. N	W Washingt	on, DC 20037
	Stat Registra	-	31. Date filed (Month, Day, Year) JUN 292	3 / . F	egistrar's Signa		M.				
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		-	For State Registrar	Otato of M	iai yiaira			of Death				2010	21945
	Physicia	n/	1. Decedent's Name (First, Middle, L	ast)						2. Date of De Month			3. Time of Death
	Medic	al	Thelma Gorin							June 2	25,	2010	4:40 A M
€	Examin	er	4a. Facility Name (if not institution, gi	,				own, or Locatio				. County of Dea	
	Funeral		Alfred House Ass 5. Social Security Number 6.	Sex 7. Ac	ng je (In yrs. last	birthday)	If Under 1	ockvill Year If Und	ler 24 Hrs.	8. Date of Bir	th	Montgome 9. Bir	thplace (State or Foreign
	Director		329-16-4945	1 □ M 2 🗶 F	8	6 Yrs.	Months	Days Hours	Min.	10/25/	y, Year) 1923	Co	III
DOK	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation						10d. Inside City Limits
	Aaryla 8a-f s tified	rect	MD Montgo	omerv		Rock	ville						1 🗌 Yes 2 🌠 No
	a or 2 be no	Funeral Director	10e. Street and Number	ZMCLY		ROCK	10f. Zip 0	Code			10g. Ci	itizen of What Co	ountry?
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10	or iter	by Fu	11. Marital Status1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 \square Yes 2 \textbf{X}	Ever in U.S.	13. V	Vas Decede Yes, specif	nt of Hispanic 0 y Cuban, Mexic	Origin? (Spe can, Puerto	cify Yes or No- Rican, etc.)		 Race - Ame Black, Whit 	
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Maryland 21215-0036	should and h is ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (r, City o	r Town, State, Zi	p Code)
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3	X Removal from State	cem	etery, crem	sition (Name atory or oth	er place)		Date		ocation - City or	·
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			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that cause	d the death. D								Approximate Interval Between
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Вох	eath of atter	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 🛛 No	1 Live Birth 4 Pregnant a			Other (spec					Month	Day Year
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E E	sician; The certificate rector, pag		25. Was case referred to medical					26. Place of De	eath (Check		rmed? 2 X N	o 1 Yes	s 2 X No
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of	ding Pr th. After th funeral		27. Manner of Death 1	28a. Date of inju (Month, Da	ıry 281 y, Year)	b. Time of injury	280	o. Injury at work?		28d. Describe h			
ion	• Attendill er death. • ector: Af by the fu	Certificate:	2 Accident Investigati 3 Suicide 6 Could not	he		·	М	1 Yes 2	-			-	
Division	after after Direc		4 Homicide determine			, tarm, stre	et, tactory, o	office		28f. Location (S City or Tow			ral Route Number,
	Hospital or Attending Prystolan; The law requires that the death certificate 44 hours after death. Funeral Director: After this certificate has been signed by the attending phy sted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 X Certifying Ph	ysician: To the best of	my knowledg	je, death o	ccured at th	e time, date an	d place, an	d due to the ca	use(s) ar	nd manner as sta	ated.
	Io the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th		only one) 3 Certifying Nu	miner: On the basis of e urse Practioner: To the	examination an best of my kn	d/or investi owledge, d	eath occurre	d at the time, da	ate and plac	the time, date a e, and due to th	nd place e cause(e, and due to the s) and manner as	cause(s) and manner stated. stated.
	0 10 M	1	29b. Signature and title of certifier	1 (au	ele	er	29c. l	icense number	r		29d. Da	ate signed (Monta	h, Day, Year)
D	B 3	-	30. Name and address of person who	1				D25410			Ju	ne 25. 2	2010
			Oliver J. Lawl		,			ip Dr.	01nev	, MD 20)832		
	Stat	5	31. Date filed (Month, Day, Year) JUN 2 9 20	32 Registra	ar's Signature	ha	N.S.						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:35 P M 2 2010 1/1am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner albo TALBOT HOSPICE HOUSE TON If Under Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, **Funeral** Months Min 1**X** M 2□ F Days Hours Director NEAVITT, 220-26-3917 80 MD Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ttem 27 Is marked other than "natural", or items 23a or 28a-f shother traumatic event, Inc. Medical Examinate must be notified 1 □Yes 2X No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29192 RABBIT HILL ROAD 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE þ If Yes. Give Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE Hygiene. 1 and 2 should be filed wi Health and Mental Hygier em 27 Is marked other th LIFE INSURANCE AGENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM R. HUNT MARGARET HADDAWAY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a TIM HUNT, SON 1011 RADIANCE DRIVE, CAMBRIDGE, MD permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OXFORD CEMETERY 7/1/2010 OXFORD, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P 200 SOUTH HARRISON STREET, EASTON, MD 21601 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) ince 11/CR weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Physician/Medical e attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed by Hospital or Attending Physician: The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2. No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 In Nursing Home 5 In Residence 6 MacOther (Specify) HOSPICE Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: completely filled in by the 3 Suicide 6 □Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide

O. Box 68760, ۵ Division of Vital Records,

within 2

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Redistrar's Signature

park

1 Certifying Pussician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Susan

29c. License number

R124198

E.

ON

Delean

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | 21947 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11:03 A.M 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) Days Hours 1 /30 / 1 930 220-81-2810 1 X M 2 □ F Cameroon Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Howard Columbia 1X Yes 2 □ No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 9258 Curtis Drive 21045 Cameroon 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Black 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Worker Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Njaleu Njaleu unk. Koueko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henri Happi/Son 9258 Curtis Drive Columbia, Md 21045 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p. Date 1 X Burial 2 Baboutcheu Njaleu, Cremation 3X Removal from State Family Cemetery 7/17/2010 5. Other (Specify) 4 Donation Cameroon PATEDIAP ADIESROF NALDI FUNERAL SERVICE, P.A. 9241 Columbia bLvd.Silver Spring,Md20910

Physician /Medical Examiner 1-

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Examiner must be notified

Pages 1 and 2 should be filed within 72 hours after death with the Marylanc

Baltimore, Maryland 21215-0036

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physician and as the burial-trans d by the at detached f filled in by nn 24 hours
o the Funeral Diccompletely fille

the Hospital or Attending Physician; The law requires that the death certificate be executed

after death.

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Division of Vital Records, P.O. Box 68760,

shock, or heart failure. List or	omplications that caused the death. Do not ente	- 3		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	Acute mye	logenous	leukem	ia
resulting in death)	Due to (or as a consequence of):			
Sequentially list conditions,	b			
Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury	Order to (or ass a consequence on)			
that initiated events resulting in death) Last	c			
resulting in death, Last	bue to (or as a consequence of).			
'	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant condition	is contributing to death but not resulting in the u	nderlying cause given in Part I.		ouse contribute to the cause of death?
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \(\) Yes 2 \(\) No
25. Was case referred to medical examiner?	4		ath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient	3 DOA Other: 4 Nursing H	fome 5 Residence	6 Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 Suicide 6 Could no determin		et, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, te)
	Physician: To the best of my knowledge, death xaminer: On the basis of examination and/or inv and manner stated.			
29b. Signature and title of certifier		29c. License number	29d. D	Pate signed (Month, Day, Year)

RES - 000

June 21, 2010

600 North Wolfe St, Baltimore, MD, 21287

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

TO

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Miller 2010 1:45 P. M Horan Charles J<u>une</u> Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1919 1 🛣 M 2 🗆 F Days Hours July 16, Country) Virginia Director 217-16-2428 90 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington Grove Maryland Montgomery 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20880 127 Maple Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 2 □ No 1941 1 Never Married 2 X Married Completed by 1 X Yes If Yes, Give ltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: 3 Widowed 4 Divorced 1946 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Dentist Dentistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Horan John Powers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meredith Horan/Daughter Maple Road, Washington Grove, Maryland 20880 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6/29/2010 | Knoxville, Maryland 4 Donation 5 Other (Specify) St. Marks Church Cem. re of Funeral Service Leans e 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardia intaic Medical resulting in death) Due to for as a consequence of Examiner Sequentially list conditions, Examine Due to jor as a consequence of: cause. Enter Underlying Cause (Disease or iinjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown has been signed by e 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗷 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accider 5 Pending work? 1 Tes Investigation 6 Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and tipe of cer 29c. License number 29d. Date signed (Month, Day, Year) D 20148 9+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 911 Russell Avenue, Gaithersburg, Maryland 20879 Steven H. Dolinsky, M.D., 31. Date filed (Month, Day, Year)
JUN 2 9 2010 32. Registrar's Signature State Registrar

1/42/9

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21949 Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ ^D2010 Year June 26, 06:35 A M Lillian Horowitz Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec. 6,1916 1 🗆 M 2 🗆 F Months Days Hours Min. 579-01-9239 93 Washington, DC Director Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Bethesda Montgomery 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 5450 Whitley Park Terrace # 605 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🙀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian. Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: If Yes, Give Year or Dates White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vera Epstein Issac Comarow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7528 Hampden Lane, Bethesda, Maryland 20814 Dale Abrahams/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
King David Mem. Grds. XBurial 2 ☐ Cremation 3 X Removal from State 6/28/2010 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sagel Funeral Direction, Inc. M01597 <u>Melissa Greenhut</u> 1091 Rockville PIke, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction Minutes disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular Disease Years Sequentially list conditions, Examine if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran certificate be execu Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an COPD this certificate has page 2 s autopsy performed Yes 2 1 ☐ Yes 2 🌁 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica of Vital 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 🔀 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ♣ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury_at Natural 5 Pending 1 Yes 2 No Investigation by the f Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in rity opinion, usaut occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D53367 June 27, 2010

State

Registrar

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Georgia Avenue, Suite 117 Silver Spring, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shyamsundar Rajan,

31. Date filed (Month, Day, Year)

JUN 29

MD

32_Registrar's Signature

9801

			Plea	se Type or						_		-	le.		
			For State Registrar	State	ot Marylan		artment of h <i>rtificate of</i>		and N	nental Hy	giene Reg. No		n	219	50
	Physicia	an	1. Decedent's Name (First, Middl							2. Date of De Month			Year	3. Time of D	
	/Medic	al	Eleanor Jane I 4a. Facility Name (If not institution		ımber)		4b. City, Town, c	or Location	of Death	06	4c.	County of	C/O Death	133	А м
	Examin	er	17601 Taylors	-			Sharp	sburg				ashi	ngto		
	Funeral Director		5. Social Security Number 215–18–2683	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs.	last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Jan. 1	rth lay, Year) 7, 19	924	Count	ace (State or large) Land	Foreign
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10	d. Inside City	
	ne Mar 18a-fsl	ector	Maryland Washi	ngton	Sha	rpsburg					10~ Citi	zen of Wh	not Count	1 □ Yes 2	No No
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0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Modical Examinar must be redition at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Mar	ried Armed F 1 □Yes If Yes. G	2 🔀 No live		Was Decedent of I f Yes, spedify Cub	an, Mexica	n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race Black, Specify:	, White, e		
200-0	2 hours atural"		3 ☐ Widowed 4 ☐ Divorced	nt's Education		16a. Dece	dent's Usual Occu	pation		·	16b. Ki	nd of Bus	iness/Ind	ustry	
1713	within 7; iene. • than "n	Completed	(Specify only higher Elementary/Secondary (0-12)	College) (1-4or 5+)		kind of work done DO NOT use retire emaker	auring mos ed)	ST OT WORK	ing	h	er ow	vn ho	me	
ם ב	tal Hyg d other svent,	Be	17. Father's Name (First, Middle,					18. Moth	er's Nam	e (First, Middle)		
ryla	hould to d Men marker matic	٢	Orvill 19a. Informant's Name/Relations	e Shinhan	1	19h Mailir	ng Address (Stree	t and Numb	er or Ru	Eleano			State, Zip	Code)	
, Z	and 2 s ealth ar n 27 is ner trau		Gerald A. Kell			1760	1 Taylor	s Lan	ding	Road,	Shar	psbu	rg,	MD 2178	82
nore	ages 1, ent of He it; If iten y or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State Lit	Place of Dispo cemetery, cren ttle Ro	sition (Name of natory or other pla ose Hill Cemete	ice)	une	29 310		cation - C		wn, State , Mary]	Land
dillinor	permit. F Departmo Importan any injur once.		21. Signature of Funeral Service			22	2. Name and Addr	ess of Facili			FUNER	AL H	OME		
Δ	ă o = ≅ a		23a. Part 1. Enter the disease, o	r complications that	caused the deat		5 E. W11					m, M	d. 2	Approximate	
F	hysician		shock, or heart failure. List Immediate Cause (Final disease or condition			mee	ocarlest	in	Den	Tion				Interval Betwo	eath
ر ا	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of									
	sit sed	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	o (or as a consec	quence of):									
Ď.	e execuran and rial-trar	Ш	that initiated events resulting in death) Last	c Due to	o (or as a consec	quence of):									
00/00	physici	dical		d											
J. DOX	To the Nexpital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Lip the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live	utcome of pregn birth 2 Feta gnant at time of	al death 3	☐ Ectopic pregnan ☐ Other <i>(specify)</i>	су				23d. Date Mon			ear
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SION .	tending eath. Ior: Affe the fun	catio	1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	igation	inth, Day, Year)	Injury	M 1 [Yes 2]No						
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	withi Com	ğ	29b. Signature and title of certifie		Lut			se number	18	•		1		Day, Year)	
	7		30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type,	Print) d Dr.	Koo	du	511:1 K	n	1 5	7175	6	
F	Sta		31. Date filed (Month, Day, Year,	2010 32/	Registrar's Sign	ature 1	4 2	if for on	-/-	-61/16	/				
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Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			State of Maryla					_	ie.
	•	For State Registrar	Otate of Maryla		rtificate of L			9. No. 20	10 21051
Dhusisis	/	Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
Physicia Medic		Stephen Daniel Ke					June 26	1	9:30 A M
Examin	er	4a. Facility Name (if not institution, give si Manor Care Bethes	·			r Location of Death .esda		4c. County of D	
Funeral		5. Social Security Number 6. Sex	Two Dr	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	g.	Birthplace (State or Foreign
Director		412-56-2104 Usual Residence of Decedent	74	Yrs.		1100.00	08/13/1	935 N	Country) [ew York
land show d at	tor	10a. State 10b. County	10c. C	City, Town or Lo	ocation		·		10d. Inside City Limits
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eath wi	nne	3503 Kensington C	12. Was Decedent Ever in U	J.S. 13.	20895 Was Decedent of H				American Indian,
fter de , or it amine	þ	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes. Give		If Yes, specify Cuba 1 ☐ Yes 2 X No	ın, Mexican, Puerto	Rican, etc.)	Black, V	Vhite, etc.
ours a tural'	eted	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates.	1 40° D					White
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ould b nd Me mark mark	ľ	19a. Informant's Name/Relationship (Typ		10h Mail	ing Address (Street				Zin Codel
id 2 sh salth ar n 27 is er trau		Mary Ann Keeffe (yland 20895
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	cemetery, cre	osition (Name of matory or other place itan Crem		ne 2/	oc. Location - City Alexandr	y or Town, State
permit. I Departir Importa any inju once.		21. Signature of Funeral Service License	100	ho.	2. Name and Addre		Vol Fune		
00 = g 0	Ш	23a. Part 1. Enter the disease, or compli	ention that caused the de						g, MD. 20877
Physician/ Medical		shock, of heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Metastatio	: Carci			or respiratory arrest	,	Approximate Interval Between Onset and Death Months
Examiner		resulting in death)	Due to (or as a conse	quence of):					
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ss that igned I	by	Part II. Other significant conditions con	tributing to death but not r	esulting in the	underlying cause giv	ven in Part I.			te to the cause of death?
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sician: The law is certificate has the law irector, page 2 s	Completed						24a. Was an autopsy performe	prior deat	e autopsy findings available r to completion of cause of h?
an: Th tificate tor, pa	Be Co	25. Was case referred to medical			26. PI	ace of Death (Chec	1 L Yes 2 k only one)	X No 1 □	Yes 2 No
hysici his cer I direc	To E	I Li Yes 2 LA No	ospital: 1	-		er: 4X Nursing Ho	ome 5 Residenc	ce 6 Other (S	pecify)
ending Peath. or: After the funera	Certificate:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work		28d. Describe how	injury occurred	
tal or Att rs after do al Directo ed in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (Stree City or Town, S		r Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Examine	cian: To the best of my kno er: On the basis of examinat Practioner: To the best of	ion and/or inve	stigation, in my opinio	on, death occurred a	t the time, date and I	place, and due to	the cause(s) and manner stated.
To t with To tl		29b. Signature and title of certifier	Dayler -		29c. License	e number		d. Date signed (M	
5		M.S.N		00) =		874		June 27,	2010
		30. Name and address of person who co S.M. Nayar M.D. 3				y, Maryla	and 20722		
Stat	e.	31. Date filed (Month, Day, Year)	3. Registrar's Sign	nature _	Ked.	<u> </u>			
Registra	ir	JUN 29 2010	Chromas A	7. Jag 64	April -				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Seasons Hospice <u>Randallstown</u> Baltimore Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min (Month, Day, Country 1 X M 2 D F 9, **Director** Yrs. 218-24-0072 81 1928 Pennsylvania 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20603 <u>3285 Captain Dement Drive</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Specify: 3 Widowed 4 Divorced White Year or Dates. permit, Page 1 and 2 should be filed within 72 houn Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Contractor <u>Construction</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Raymond Morauer Maria Thumm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3285 Captain Dement Dr. Waldorf, Maryland 20603 Geraldine K. Morauer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔲 Burial 2 💢 Cremation 3 🗍 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Glen Bernie, MD <u>Atlantic</u> Crematory July 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Lic 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the defin. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of such line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ned man disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, Yes 2 No 3 Probably as been signal Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 2 🗆 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 မ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day), 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Acciden 3 Suicide iniury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 28e. Placer f Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number

Registrar

State

31. Date filed (Mo

Box 68760

Division of Vital

erand address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g905 7-14-10 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No 201 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Mooney 8:35 P M 2010 June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3733 Pecan Court Waldorf Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Figure 1, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) New York Sex 1XXM 2 □ F 7. Age (In yrs, last birthday) Funeral Director 125-36-5405 12 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10h County 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 □ No Maryland Charles Waldorf 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3733 Pecan Court 20602 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No If Yes, Give Black, White, etc. 2 1 Never Married 2 M Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 ral Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) UNISYS CORP 4+ S<u>vstems Engineer</u> 12 Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked off
any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francis Mooney Genevieve Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Linda Mooney/ Wife</u> Pecan Ct. Waldorf, Maryland 20602 20a. Method of Disposition
1 Å Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Arlington Nat. Cem. Sept. 1, 2010 Arlington, VA 21. Signature of Funeral Service 22, Name and Address of Facility Huntt Funeral Home 20601 Old Washington Rd, Waldorf, MD cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine and the burial-tran Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 🗌 Yes 2 No 3 Probably 4 Shknown completed filled in by the funeral director, page 2 should le 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 25. Was case referred to medica Be **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 10 မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Natural death. Accident Suicide Investigation within 24 hours after deat To the Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOOW! 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 29 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 1 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27 20 D Physician/ M A 01:61 Grant Mahan Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Wicomico Hospice at the Birthplace (State or Foreign Country) cial Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr 8. Date of Birth **Funeral** (Month, Day, Yea 09/03/192 1 🛛 M 2 🗆 F 82 197-24-4448 Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗆 Yes 2 🎽 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 21804 USA 314 Wyman Drive . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: white Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) public education 5+12 teacher Be 18. Mother's Name (First, Middle, Maiden Surname)
Chloa Kreider 17. Father's Name (First, Middle, Last) ပ Walter K. Mahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Wyman Dr., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type, Print) E. Louise Mahan/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Springhill Memory Gardens 1 XI Burial 2 Cremation 3 Removal from State 7/1/2010 Hebron, MD 4 Donation 5 Other (Specify) Si ture of Funeral Service Licensee 22. HOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 9/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause geach line. Approximate Interval Between Onset and Death Immediate Cause (Final ISAASR Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer Yes 2 has page 2 1 Yes 2 No certificate funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? P 2 No HOSPIGE 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) Manner of De th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A ☐ Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопрете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 20058416 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAUSBUR mo 80 P 2/802 6 Huysun 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

HIN 3 U 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JUNIOR LLOYD MANAHAN June 2010 10:15 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8633 Links Bridge Lane Thurmont Frederick If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Year) 1 X M 2 □ F **Director** 69 July 6, 1940 Maryland 218-38-0922 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🔯 No Director MD Frederick Thurmont 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number items 23a or 8633 Links Bridge Lane 21788 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No by Specify: White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automobile 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lloyd Morris Manahan Ruth Naomi Bowman ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Kelly Grimes/ Daughter 28 North Carroll Street, Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of F Important: If itel 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury o Resthaven Mem. Grds.: 6/28/10 Frederick, Maryland 21. Signature of Funeral Service Lies ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 discusse, or complicitions that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one was eon, and inc. Approximate Interval Between Onset and Death 23a Part 1 Enter the shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) **Physician** TUNSHOT ninutes Wound /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: the death certificate be executed Due to (or as a consequence of) physician the burial P.O. Box 68760 Physician/Medical as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 5 Other (specify) ☐Yes 2 ☐ No ned by the 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed? Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Individual 1 Natural 5 Pending investigation shot self in the head June 23 2010 8 PM 15 28e. Place of Injury. At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 No 2 Accident 3 Suicide 4 ☐ Homicide 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State \$633 Links Bridge Lane determined home Thurmone, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eet, Frederick, MD21701 DME

State Registrar

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31. Date filed (Month, Day, Year)

of Vital

Division

32. Registrar's Signature

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Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of cert

31. Date filed (Month. Day.

Box 68760

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License numbe

D0058726

CT., MYERSVILLE,

29d. Date signed (Month, Day, Year)

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JUNE 25,

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** June 24, MARY CATHERINE MINER 2010 3:05か.m. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Autumn Assisted Living Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 2, 1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2**X** F 213-24-9919 98 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Exaction must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 11013A Coffman Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: ⋧ 3₺ Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) homemaker her own home 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Charles Alvey Williams Nellie Seigman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frances Alton - daughter 21740 11013B Coffman Avenue, Hagerstown, Maryland Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State June 28, 2010 Rest Haven Cemetery Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Schools Cardo Varile Duren **Physician** Anterio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter uncernying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: for use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Inknown 1 Tyes page 2 should Completed Acciden 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? this certificate 1 ☐Yes 2 ☐No Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) \(\text{LV/NC} \) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month

to

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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HACERSTOWN MD 21740

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1 - State Registrar 1. Decedent's Name (First, Middle, Last,		Certificate	of Death		Reg. No. U	0	2 9	9 5 8 of Death
sician ledical	MARILYN KELLEY	NAUGHTON			06	23 20	Year 010	6:55	A M
niner	4a. Facility Name (If not institution, give TALBOT HOSPICE HO	USE	E	own, or Location of Death			ALBO'	Γ	
ral or	5. Social Security Number 6. Septimber 217–28–0444 Usual Residence of Decedent	7. Age (In yrs.	Yrs. If Under Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Bir (Month, Da	1932	9. Birth	place (State intry)	_
by Funeral Director	10a. State 10b. County	10c. Ci	ty, Town or Location					10d. Inside (
Director	MD TALBOT		EASTON						s 2 No
ä	10e. Street and Number 28433 CANVASBACK I	ANTE	10f. Zip (21601		10g. Citizen of V			
by Funeral		12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	l.S. 13. Was Deceder If Yes, specion 1 □ Yes 2.	nt of Hispanic Origin? (S y Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Rac Blac		ican Indian, etc.	
Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Usual (Give kind of work	Occupation done during most of work retired)	king	16b. Kind of Bu	siness/Ir	ndustry	
ошр	Elementary/Secondary (0-12)	College (1-4or 5+)	INTERIOR DE	ŕ		INTERIO) DEC	ተፑል ቁጥ	NC
BeC	17. Father's Name (First, Middle, Last)		THE DESCRIPTION OF	18. Mother's Nam	ne (First, Middle			JUINIT	NG
2	ESTEL KELLEY			ZELDA	COULTER	<u> </u>			
	19a. Informant's Name/Relationship (Ty) BARBARA AYERS/NIEC	•		Street and Number or Ru		-		p Code)	
	20a. Method of Disposition 1 Burial 2 **Cremation 3 B A 4 Donation 5 Other (Specify)		Place of Disposition (Name cametery, Crematory or off ESAPEAKE CRECENTER	ASBACK LANE,		20c. Location -	•		
	21. Signature of Funeral Service License	ee 🔿	FELLOWS	Address of Facility HELFENBET TH HARRISON	N & NEWI	NAM FUNE	RAL		P.A.
Medical Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line. Due to (or as a consequence of the consequence	juence of):	or dying, such as cardiac	or respiratory a	irrest,		Approxima Interval Conset and	atween I Death
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 Ectopic pre			23d. Dat Mo		very Day	Year
Completed by Ph	Part II. Other significant conditions con	CLEROSIS	With PA	rapares is	1 🗆 `		3□ Pro	bably 4	Unknown
	ATHEROSCLERO	TIL CAZIDIO	suscul		perfo	2 No 1	Vere autorior to co leath?	opsy findings ompletion of 2 A No	s available cause of
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other: 4 Nursing H		one) dence 6 X Oth	er (Space	(b) LbST	PILE
Certification; T	27. Manner of Death 1 Natural 2	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At he building, etc. (Specification)	28b. Time of Injury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe I	how injury occurr	ed		
Medical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	ician: To the best of my knoter: On the basis of examination and manner stated.	owledge, death occurred a ation and/or investigation,	t the time, date and place n my opinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	inner as and due t	stated. to the cause	(s)
Me	29b. Signature and title of certifier	- ATTENDING		0053094		29d. Date signed	(Month,	Day, Year)	
	30. Name and address of person who con	npleted cause of death (Item 32. Registrar's Signa	21 BLOOMIA	IGDALE AUE	FEDER	ALSBUR	6, d	ON	

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Paul Oros Sr. Physician/ Joseph Month 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** lisbur) icom ico If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 88 yrs. **Funeral** 1 **X** M 2 □ F Days Months 0471071922 Kentucky Director 236-28-4932 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 K No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21801 26842 Hamden Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No. If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 X Divorced Year or Dates Guard 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) general accounting 12 management assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Bakati George Oros, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26842 Hamden Dr., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type, Print) Joseph Paul Oros Jr/son Joseph 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place Eastern Shore of MD Veterans Cemetery 1 🖾 Burial 2 🗌 Cremation 3 🗍 Removal from State 6/30/2010 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 9 501 Snow Hill Rd., Salisbury, MD 21804 Kompos 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DEMENTIA Immediate Cause (Final Proysician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2/1 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 NO certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2/19 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: Natural 2 Accident (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ceratifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DHMH 17 Rev 7/2009 only one)

29b. Signature and title

(Haran

31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B0 0

32, Registrar's Signature

732

29d. Date signed (Month, Day, Year)

Staggun

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	_	State Registrar			Cen	tificate of E	Death		eg. No. 2	010	21960
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Examin		4a. Facility Name (if not institution, gives 509 Moore Stre				•	Location of Death	v		nty of Death	r
Funeral		Social Security Number 6. Se	7. Ag	je (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth			olace (State or Foreign
Director ≽		Usual Residence of Decedent	1M 2 X F 63		Yrs.			6 – 8 – 1 9	47		
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n the M a or 28 be not	al Dir	10e. Street and Number		1 000		10f. Zip Code			10g. Citizen	of What Cour	ntry?
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ter c	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give		lf	Yes, specify Cubar ☐ Yes 2 🔀 No	n, Mexican, Puerto	Rican, etc.)	Е	Black, White,	etc.
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2 should be th and Ment 27 Is marked traumatic e	ပ္	Charles Smith 19a, Informant's Name/Relationship (Ty)		1.	Sr.	n Addrage (Street s	Fern Je				Codel
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permit. Pa Departme Importan any injury once.		4 ☐ Donation 5 ☐ Other (Specify 21, Signature of Funeral Service License		Garr	22.	Name and Address	/VA7-9-				Ls, MD
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Physician/		23a. Part 1. Enler the dis Lise, or comp shock, or heart fill re. List only on Immediate Cause (Final	cations that cause e cause on each lin	e.	not ente	Atto	rw Scl	or respiratory arre	st,		Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequence	gft):	- Allino	100/24	0 00019			
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or Attending Physician: The law requires that the death certificate after death. Director: After this certificate has been signed by the attending phy. in by the funeral director, page 2 should be detached for use as the	by Physician/Medio	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 4 Pregnant a 9 Unknown			Ectopic pregnance Other (specify)	у			Month	Day Year
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Physic this cerral dire	욘	1 Yes 2 No	ospital: 1 Inpat 28a. Date of inju	ient 2 ER/0	Outpatien	3 DOA Othe	4 U Nursing Ho	ome 5 Reside)
ending sath. or: After he fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Da		injury	work		Zod. Describe ne	www.mjary.coc		
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To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical		er: On the basis of e	examination and	l/or investi	gation, in my opinic	n, death occurred a	t the time, date an	d place, and	due to the ca	use(s) and manner stated.
To the within 2 To the comple	ž	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the	best of my kno	wledge, d	eath occurred at the 29c. License			9d. Date sig	ned (Month,	Day, Year)
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		30. Name and address of person who co		leath (Item 23a	(Type, Pi	onok	e, r	1) &	185	/	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Maria Patterson Dana 1:52PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Salisbur HOSpice Se Wicomico If Under 24 Hrs. 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗓 F 08/12/1958 Country) Florida 51 216-70-0945 Director Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Salisbury Wicomico Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21801 1209 Shawnee Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 X Never Married 2 Married þ ☐ Yes Baltimore, Maryland 21215-0036 African/ 1 Yes 2 No Specify permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", If Yes, Give 3 Divorced 4 Divorced Completed American Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) line worker poultry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edith Hunter Willie Patterson 19a. Informant's Name/Relationship (Type, Print) Bb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
811 N. Division St., Apt. 3, Salisbury, MD 21801 Taron P. Dutton/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Salisbury Crematory 6/28/2010 Salisbury, MD 4 Donation 5 Other Specify SI e of Fune al Se ANTIOWAY FULLER Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 art 1. Enter the disease, or complicati that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death nock, or heart failure. List only one Immediate Cause (Final Priysician/ CARCINOWA -ASTRIC isease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 ponths? Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🛮 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan cate has page 2 s autopsy this certificate 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 🗗 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury After 5 Pending iniury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completed filled in by the fu death. Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GHUMA 130 21802 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOHN 22 21 YNN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 21610 DEEP HARBOR FARM ROAD SHERWOOD TALBOT 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1**X** M 2□ F Months Days Hours Min. 78 01/02/1932 **Director** 109-24-3500 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Evanance rust be notified at Director 1 ☐ Yes 2 ▼ No TALBOT SHERWOOD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21610 DEEP HARBOR FARM ROAD 21665 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No ģ Specify Specify: WHITE 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 MECHANICAL ENGINEER MEDICAL DEVICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be file tment of Health and Mental H tant; If item 27 is marked oth WILLIAM H. PYNN MERIDA PITMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN MARIE PYNN/WIFE 21610 DEEP HARBOR FARM RD., SHERWOOD, MD permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ST. JOSEPH'S CEMETERY 06/28/2010 CORDOVA, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 CHOP MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final MESOTHELIOMA **Physician** MALIGNANI 34ns. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Ditis to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hlnknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No has 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No After this certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💆 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural I Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a Certifier within 2 To the

State Registrar

12+VA

Division of Vital Records, P.O. Box 68760

29b. Signature and title of certifier

31. Date filed (Month,

vur

JUN 2 4 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATTERSON

Gener S. park

800 S. TALBOTSI

attle gu my

32. Registrar's Signature

29c. License number

D0057608

29d. Date signed (Month, Day, Year) 6/23/10

MD

MICHAELS

21663

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 21963 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month Pine 26 Irvin June 11:00 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 427 Christopher Avenue, Montgomery Gaithersburg Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth (Month, Day, Jan . 29 9. Birthplace (State or Foreign **Funeral** 1 ፟፟ M 2 □ F Days Hours Min. Virginia Director 225-09-4706 93 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20879 United States 427 Christopher Avenue, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Pichalek Tabe Bomilter Max 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # 24, Gaithersburg, MD. 20879 Barbara A. Pine/Spouse Christopher Ave., 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State injury 4 Donation 5 Other (Specify) King David Mem. Cem. 6/28/2010 Falls Church, Virginia 21. Signal re of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiovascular Disease Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a Was an page 2 s autopsy performed Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending injury s after death. Accident Investigation ipleted filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral I Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 27, 2010 D 63195 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Steven Wilks, M.D.,

JUN 29 2010

31. Date filed (Month, Day, Year)

/32. Registrar's Signature

8600 Old Georgetown Road, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar		State of Ma	aryland	/ Depa	irtment of H tificate of D	ealth and N <i>eath</i>	/lental Hy	giene Reg. N	201	0	21964
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Physic Med		OPHELIA V	WITHERS F	INKNEY					06/23	<u>/201</u>	Ö	ear 	08:27 A ^M
Exam	iner	4a. Facility Name (if		· ·	. .		4b. City, Town, or	Location of Death			c. County of		1
		Southern 5. Social Security Nu		Hospital	Cente (In yrs. last		Clinton If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		rince		orge's
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e, IVI and 2 sl Health a tem 27 is		Thomas Wi	ithers -	son		12600	Van Brad	dy Road,	Upper M	Marl	boro,	MD	20772
ore, e 1 and or of Hea if item		20a. Method of Disp		Removal from State	20b. Plac	e of Dispos	sition (Name of eatory or other place	9)	Date	20c. l	Location - Ci	ty or To	wn, State
Dall timor bermit. Page 1 Department of Important; If it any injury or o		4 Donation	5 Other (Specif	y) \(\tag{/}	1 /	at/1	Mem Park	6/30			rel, N		
DESILITION FOR THIS TOTATION OF LATE 19-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anones.		21. Si natuka Fun	neral Service Lice	Lea	uch	A/C	Name and Address		snowden St, Rock				
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CIVISION all or Attendir s after death. al Director: Af	Ħ	3 Suicide 4 Homicide	6 Could not b	e 28e. Place of Inju		e, farm, stre						r Rural	Route Number,
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical	(Check 2	☐ Medical Exami	sician: To the best of iner: On the basis of ex se Practioner: To the l	camination ar	nd/or invest	gation, in my opinio	n, death occurred a	t the time, date a	and plac	e, and due to	the cau	use(s) and manner stated.
To the vithii To the comp		OGL Cimpture and t	itle of certifier		. 1		29c. License	number		29d. D	ate signed (/\	∕lonth, l	Day, Year)
2		P	on Fr	~ ^	IV.		10	13446			6-29	S - 6	2010
		30. Name and addre	TAN FA	completed cause of de RAHIFAR 32. Registra	eath (Item 23	Ba) (Type, P	rint) 12150 An	rapolis R	Load. Su	n ti	312 6	rlon	20769
St Regist	ate rar	31. Date filed (Month	N 29 2010	32. Registra	r's Signature	Lane	Led a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20/0 Day Physician/ Month 0 620 M E104 Jun Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, 4c. County of Death **Examiner** mon g 5 0 5 N Social Security Number 6. Sex 1 M 2 □ F J. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours AUG 19, Director 215-21-3275 48 Mexico Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🗓 No MD Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2533 Glenallan Avenue, #204 20906 Mexico 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No 1 X Never Married 2 Married þ Maryland 21215-0036 1 X Yes 2 □ No Specify: Mexican If Yes, Give Specify: Caucasian Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction Stone Mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Victorio Rubio Lozano Martinez Covarrubias 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonio Rubio Martinez/ Brother 301 Chester Drive, Friendswood, TX 77546 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 06/29/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligenses 22 Name and Address of Facility
Thibadeau Mortuary Service, P.A. M00956 7 Park Avenue, Gaithersburg, MD 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Resmany Fig. Physician, disease or condition resulting in death) Talle Medical Examiner Daz Traumatie Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant Pregnant at time of death 5 Other (specify) ☐ Yes ☐ ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 No. 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital: 1 ➡Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Ves 2 No |은 4 Nursing Home 5 Residence 6 Other (Specify Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred . Strect 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 🗆 Natural 5 Pending 2 Accident Jun 13 2010 5500W C10451m Investigation Venicle 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number of City or Town, State) VIEVS MILL STAN, M. 3 ☐ Sulcide 4 ☐ Homicide determined R 6216 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNE 23,2010 MN 66895 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susurban old beorgoon Rel. 40 20814 8600 Damento Hospital 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

			1 - State Registrar	e of Maryland	/ Depa	artment <i>rtificate</i>	of H	ealth a Death	and N	fental Hy	/giene 2 (10	21966
	Physic /Medi		1. Decedent's Name (First, Middle, Last) SHEILA C. SWANN							2. Date of De Month JUNE	28, 2		3. Time of Death 12: 20 P M
	Exami	ner	4a. Facility Name (If not institution, give street at FORT WASHINGTON MEDIC. 5. Social Security Number 6. Sex		hirthday)	, ,	WAS	Location o HING If Under 2	ľON	8 Date of Ri	PRINC	ty of Death	
	Funeral Director		217-12-2840 Usual Residence of Decedent		Yrs.		Days	Hours	Min.	8. Date of Bi (Month, D JANUARY	13, 1922	MARY	LAND
	death with the Maryland ms 23a or 28a-f show	ector	MARYLAND PRINCE GEORG	ES FORT		INGTO							10d. Inside City Limits 1X Yes 2 □ No
	th with the 23a or 2	Funeral Director	1313 OLD PISCATAWAY RO	OAD		10f. Zip (ode 0744				10g. Citizen o UNITED		*
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I're Medical Examire rount be notified at once.	þ	1 Never Married 2 Married 1 If Ye Yea	Decedent Ever in U.S. ed Forces? Yes 2 A No s, Give r or Dates:		lfYes, speci 1 □ Yes 2	y Cuba	Specify:	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)	Spec	DLA	etc.
21215-0036	d within 72 giene. er than "nat	Completed	15. Decedent's Education (Specify only highest grade compile) 15 Graph taps/Secondary (0-12) College Control of the Control	eted) 1 ege (1-4or 5+)	(Give life. i	dent's Usual kind of work DO NOT use TODIAL	done d retired,	urina most	of work	ing	16b. Kind of FEDERA		ERNMENT
Maryland	iould be file I Mental Hy narked oth natic event	To Be (17. Father's Name (First, Middle, Last) WILLIAM T. COLBERT					CATH	IERI	NE WARR	e, Maiden Surna RICK COL	BERT	
	1 and 2 sh Health and tem 27 is n		19a. Informant's Name/Relationship (Type. Prin. IVY HARRIS / NIECE 20a. Method of Disposition		1313	OLD P	ISCA	TAWAY	RO		RT WASHI	NGTON	I, MD 20744
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or of		1 Surial 2 Cremation 3 Removal 4 Donation 5 Other (Specify) 21 Surveyof Funeral Service J Cansee LYDIA C. THORNTON	RESU	RRECT	HORNT	EMET	ERY J	ULY :	3, 2010 OME. P.	CLINTON	I, MAR	RYLAND
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	that caused the death. [o not ent	er the mode	of dying					u, ria	Approximate Interval Between Onset and Death
8760,	ficate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequen									
P.O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	s, outcome of pregnancy Live birth 2□ Fetal de Pregnant at time of deat Unknown	ath 3 □	Ectopic pre Other (spe						ate of deliv	ery Day Year
ords, F	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing	to death but not resultin	g in the ur	nderlying cau	use give	n in Part I.			tobacco use co Yes 2 □ No	ntribute to t	he cause of death?
Vital Records,	ian: The law r rtificate has be ctor, page 2 sh	Completed	25. Was case referred to medical				-			1 □ Yes	prsy prmed? 2 No	prior to co death?	opsy findings available impletion of cause of
Division of Vi	ing After	Certification: To Be	examiner? 1	1 ☐ Inpatient 2 ☐ ER/ Date of Injury (Month, Day, Year) 28	Outpatien Time of Injury		c. Injury Work	r: 4 🗆 Nur	sing Ho		one) idence 6 □O how injury occu		fy)
Divis	tal or Attend s after death al Director: ed in by the f	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. f	Place of Injury - At home building, etc. (Specify)	farm, stre	et, factory, o	office			28f. Location (City or To	(Street and Nun wn, State)	nber or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier (Check only one) Certifying Physician: 1	o the best of my knowled the basis of examination manner stated.	dge, death and/or inv	occurred a	t the tim	e, date and inion, deat	d place, h occuri	and due to the ed at the time	e cause(s) and r , date and place	manner as s	stated. o the cause(s)
	To the P within 2 To the C complet	M	29b. Signature and title of certifier			29c.	License	number			29d. Date sign	ed (Month,	Day, Year)
	BB5		30. Name and address of person who completed ARVIND NARASIMHAN, M. I 31. Date filed (Month, Day, Year)		INGT	,	DICA	L CEN	TER		LIVING WASHING		ROAD D-20744

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21967 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 23^{Day} 2010 June CURTIS LUTHER SHUFF, JR. 3:50 Рм 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, May 30, 1 → M 2 □ F Months Days Hours 218-78-4383 50 1960 Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits 1 □Yes 2√ No Maryland Frederick Sabillasville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5640 Ft. Ritchie Road 21780 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Curtis Luther Shuff, Sr. Deanna L. Shire 19a. Informant's Name/Relationship (Type. Print) Deanna L. Shuff / Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5640 Ft. Ritchie Road, Sabillasville, MD 21780 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Blue Ridge Cemetery 6/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Thurmont, Maryland 21. Sonature of Europal Service ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or com shock, or heart failure. List only the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALENOCARCINOMA MONTHS Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ngs available of cause of

Physician /Medical Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed

Physician

/Medical

Director

Funeral

2

Completed

Be

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Accident Examination and other traumatic event, the Accident Examination and other traumatic event.

Baltimore, Maryland 21215-0036

Examir and attending physician and for use as the burial-tra Physician/Medical signed by the a ģ certificate has been s rector, page 2 should Completed Be Certification: To After this 24 hours after death in by the filled

Division of Vital Records, P.O. Box 68760,

		Yes 2 No 3 Probably 4
		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner? 1 ☐ Yes 2 MNo	26. Place of Death (Check only one)	
	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	ne 5 Residence 6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28c. Injury at Work?	8d. Describe how injury occurred

3 Suicide

investigation 6 Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

06/26/10

29a, Certifler (Check only one) 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 031761

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA Date filed (Month

State Registrar

Medical

DHMH 17 Rev 1/2001

within 2 To the I

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3UNE 1638 M Medical 4a. Facility Name (if not institution, give street and numb Examiner 4b. City. Town, or Location of Death 4c. County of Death KAGIOWAL TENINSULA edicar NICAMICO SSUSSUCCE **Funeral** Social Security Number 6. Sex Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🏻 F Days Months Min. Hours Director 4/17/1930 218-24-4908 Maryland 80 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Worcester Pocomoke City 1 Yes 2X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 2511 Olds Road 21851 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceden... Armed Forces? ¹ ☐ Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin. Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Bookkeeper</u> Automotive Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Harold Mason Margaret Wilkerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin Selby (husband) 2511 Olds Road, Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) First Baptist Cemetery 6/29/2010 Pocomoke City, MD 21. Signature of Funeral Price Licenses Professional Association 107 Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ntralenthra Medical Examiner Sequentially list conditions, Due to (or as a consequence of): If any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Exami signed by the attending physician and abe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death Month Yes 2 Unknown 5 Other (specify) Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? ည 1 🗌 Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 \square Pending work? Accident Investigation 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 de dical Examper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s), and manner stated.
3 detailed by Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier D57333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DN 5 PKush J. MEHTA E. CARROLL St. SAlisbury Ma mD 100

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2

		•	State Registrar			Cei	tificate of	Death	Re	g. No. 201	21969
	Physici	an	1. Decedent's Name (First, Middle, L	,					2. Date of Death Month	Day Year	3. Time of Death
	/Medic			Louise SN					June 26,		7:35ам
	Examir	er	4a. Facility Name (If not institution, g		er)		4b. City, Town, or Hager:	r Location of Death	1	4c. County of Dea Washingt	
) leaded			1211 Peppercorn 5. Social Security Number 6.		Age (In vrs. last	hirthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	9. Bir	thplace (State or Foreign
	Funeral Director		220-26-5609 Usual Residence of Decedent	1 □ M 2 🖾 F	0 , 2	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 18	, 1929 Ma	ryland
	land ow		10a. State 10b. County		10c. City, To	own or Lo	cation				10d. Inside City Limits
	Mary F sh	ţ	Maryland Washin	gton	Hage	ersto	wn				1 □Yes 2 □ No
	3a or 28a	Funeral Director	10e. Street and Number 1211 Peppercorn	Drive			10f. Zip Code	740	10	g. Citizen of What Co	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I then 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examples of the Indifficult at the Medical Examples.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? ☑No	'	Vas Decedent of H fYes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whit Specify: V	
5-0	72 ho	eted	15. Decedent's l (Specify only highest g	Education	I 1	6a. Deced	lent's Usual Occup	ation	king 1	6b. Kind of Business	/Industry
21215-0036	within 7 jiene.	Completed by	Elementary/Secondary (0-12)	College (1-4c	or 5+)		kind of work done of NOT use retired teria as:		King	school	
land	ld be filed lental Hyg ked othel ic event,	To Be C	17. Father's Name (First, Middle, Las Jenning	Brian Cra	mpton				ne (First, Middle, M.	aiden Surname) tzelbergei	2
Maryland	nd 2 shou Ith and M 27 is mar traumat	-	19a. Informant's Name/Relationship Garry Lee Snyder				-			City or Town, State,	
Baltimore,	ages 1 ar ant of Hea t: If item 3		20a. Method of Disposition 1 Burial 2 □ Cremation 3		20b. Place	e of Dispo etery, cren	sition (Name of natory or other place	ce) Tun	Date 2	Oc. Location - City or	
Baltir	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		produc	22	. Name and Addre	ss of Facility	Minnich :	Funeral Ho	<u> </u>
	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each	nline. Mere	Do not ent			-		Approximate Interval Between Opset and Death
7	Examiner	Ļ		bA	THAI		Febr	Uatro	n ·		xems
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequent	608	, M	ewit.	z P		Years
68760,	certificate be executed ding physician and se as the burial-transit	/Medical E	Todaling in doubly East	d. Due to (or a	as a consequence	ce of):	ari	- Di	iseas	e	xears.
		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	n 2 ☐ Fetal de t at time of deatl	ath 3] Ectopic pregnanc] Other <i>(specify)</i> _	у		23d. Date of de Month	blivery Day Year
ds, P	w requires that s been signed by should be deta	þ	Part II. Other significant conditions	contributing to death	but not resultin	g in the ur	derlying cause giv	en in Part I.		1	o the cause of death?
Division of Vital Records,	e la hat je 2	Completed		1 H	Mer.	len	8000		24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
tal	ician: Th certificate ector, pag		25. Was case referred to medical	100 100	100		unce	26 Place of Doc	1 ☐ Yes 2		s 2 🗆 No
>	ysicia is cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	atient 2 🗀 ER/	/Outpatien	t 3 DOA Oth	or.		nce 6 □Other (Spe	acify)
jo	ding Physician: h. After this certific funeral director,	اڃ	27. Manner of Death	28a. Date of I		b. Time of Injury	28c. Injur Worl		28d. Describe hov		
iö	endin eath. or: Af he fur	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	on	say, rear)	injury		Yes 2 □ No			
Divis	cal or Att s after de al Directe ed in by t	Certification:	3 Suicide 6 Could not determined	28e. Place of building,	Injury - At home, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	Pural Route Number,
	To the Hospital or Attendi within 24 hours after death. Caro the Funeral Director: A completely filled in by the for	Medical (29a. Certifying F (Check only pne) 1 Certifying F 2 Medical Exa	thysician: To the be miner: On the basis and manner	s of examination	dge, death and/or in	occurred at the til restigation, in my c	me, date and place pinion, death occu	e, and due to the ca urred at the time, da	use(s) and manner a te and place, and du	as stated. e to the cause(s)
	withi comp	M	29b. Signature and title of certifier	N MO	4		29c. Licens	e number 5245037	29	d. Date signed (Mon	th, Day, Year)
	7		30. Name and address of person who SHAHAB -2	completed cause o	f death (Item 23	(Type, I	Print) and	i etau	84 H.	+G MD	21740.

State Registrar For

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registra MEND#1perMD, 6-30-10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) Lloyd Eliron Smith 2. Date of Death Physician/ June Day 2010 Year 21 1:36 A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min. 8 2 4 7 4 3 578-58-7453 Yrs. Director 66 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No MD Prince Georges District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20747 2221 Roslyn Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Professional Driver Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gordon Smith Martha Virginia Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Wilma Juanita Smith/Wife Roslyn Ave. District Heights, MD 20747 or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial 20a. Method of Disposition 20c. Location - City or Town, State ŏ Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/26/2010 Suitland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licenses cc0278 Washington, DC 2001L Ave. NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician Pulmonary Embolism Medical resulting in death) Due to (or as a consequence of): Examiner Rene cute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of, burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No eral Director: After this certificate filled in by the funeral director, pag 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 XNo Other: မ 1 Minpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or At within 24 hours after or To the Funeral Direct 4 Homicide determined City or Town, State) Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06/2 2010 20

State Registrar 30. Name and address of persen who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

10-04776 John Hongkuso

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2010 21971

		1- For State Registrar	Certificate of	Death		F	eg. No.	10 2131
Physici ledical Exam		1. Decedent's Name (First, Middle,Last) John Hongku So				2. Date of Dea Month June 25,	Day Year	3. Time of Death 1220 hrs
		Facility Name (if not institution, give street and number) Route 97 and Route 144		b. City, Town, o	or Location of De	eath	4c. County of D Howard	eath
Funeral Director			yrs. last birthday) 4 Yrs.	If Under 1 Ye				Birthplace (State or preign County) Korea
w any		Usual Residence of Decedent	City, Town or Locati	on Od				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ţ	10e. Street and Number		10f. Zip Code			0g. Citizen of What (1 Yes 2 X No
th the Mai 23a or 28 notified a	al Director	14821 Burnt Woods Road		21	738		USA	
215-0036 be filed within 72 hours after death with the Maryland mil Hygiens received with the Maryland red Hydrother than "natural", or items 23a or 28a-fish ent, the Medical Examiner must be notified at once	/ Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 3 Widowed 4 Divorced If Yes, Give Year	√o If Y∈	s Decedent of Hes, specify Cuba	n, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	o- 14. Race - Al White, et Specify:	merican Indian, Black, c. Asian
hours af natural Xamin	ed by	15. Decedent's Education (Specify only highest grade completed	d) 16a. Decedent	's Usual Occup	ation (Give kind e. DO NOT use		16b. Kind of Busine	ess/Industry
136 thin 72 houe. than "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		ntracto		ŕ	Const	ruction
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	e Con	17. Father's Name (First, Middle, Last) Yun Suk So				ame (First, Middle,	Maiden Surname)	
2 a & a y	e	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Stre			nber, City or Town, S	tate, Zip Code)
and 2 shou fealth and I tem 27 is n		Hye Kyung So/Wife 20a Method of Disposition 2	1482 0b. Place of Disposi			ds Road	Glenwoo	d,Md 21738
of H		1 X Burial 2 Cremation 3 Removal from State 1 Dongston, 5 Other Specify	crematory or oth National	er place) Mem . I	Park 6	/30/201	Falls	Church, VA.
Baltimo permit. Pag Department Important:	i) /i	21. Sign fur of Experies Septile Livery les	92	241 Co.	lumbia	Blvd.S	ilver Sp	VICE,P.A. ring,Md2091
Physician /M i I		23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.	eath. Do not enter th	e mode of dying	, such as cardia	ac or respiratory an	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence)	ce of):					
	je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	ce of):					=
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)	ce of):					
760, cate be executed physician and he burial - transi		d						
760, icate be executed physician and the burial - trans	Medical	UNPENDED X AMENDED #8 per Fh IF FEMALE: 23c. If yes, outcome of p	G909 11/8 pregnancy	/10 TT			23d. Date of deli	verv
		23b. Was decedent pregnant in the past 12 months?	2 Feta		Ectopic pre	gnancy	Month	Day Year
Box 68 e death certif the attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown	J Otti	er (Specify)				
P.O.	by	Part II. Other significant conditions contributing to death but n	ot resulting in the ur	nderlying cause	given in Part I.			e to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 68. Is at Arterding Physician: The law requires that the death certificate and Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as 1	Completed			_		24a. Was		e autopsy findings available to completion of cause of
Reco The law cate has	omp	110.00					med? death	1?
ital lician: s certifi irector,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatient		e of Death (Che		Residence 6 🗸 0	ther Scane
ing Phy After thi funeral d	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of In		ary at Work?	28d. Describe	now injury occurred an truck collisio	
	catio	1 Natural 5 Pending Jun 25, 2010 Pending Investigation	1155 hrs		Yes 2 No	-		
Divisipital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Major R	oad / Highway	, тастогу, опісе	bullaing, etc.	or Town, S		Rural Route Number, City
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination						
	Medical	29b. Signature and title of certifier		29c. Licen			29d. Date signed (
5				O.C.	M.E.		June 26, 2010	
OCME		30. Name and address of person who completed cause of death (1 Mary G. Ripple MD. Deputy Chief Medical E.	vaminar 111	Penn Stree	t, Baltimore,	MD 21201		
St Regist	tate trar	31. Date filed (Month, Day, Year) 34. Registrar's Sign 2 9 2010	nafire fact					

Please Type or Print in Black Indelible Inky / Engure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 4gnes 6 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner klalcherf T-3 Charles Amber 2000 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 💢 F 78 212-32-0698 Yrs. MARTIANCE Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Waldot Director Chn-les Mary And 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or items. 2000 20602 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No þ Specify: 3 XWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If flem 27 is marked other than "natum any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemake 1) uneste 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Phle Circle Meice M1) Denise 20662 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State John AME Ch. -3-10 4 Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Moure 140 20608 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the conditions of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ner requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for 1 Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 No After this certificate has leen signed by the funeral director, gage 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably who known Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 ANo certificate Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□[No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? Hospital or Attending 5 ☐Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20646 0 31. Date filed (Month, Day, 32. Registrar's Signature State JUN 30 2010 Registrar

amended item #18/wchd/map/7-8-2010
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Carl E. Selby, Sr. <u>a</u>^M 2010 6 0751 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Worcester Berlin <u> Atlantic General Hospital</u> Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 💢 M 2 🗆 F (Month, Day, Year 3 - 3 - 192 Country) MD Director 220-12-1047 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 XNo Pocomoke MD Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 33149 Peach Orchard Road 21851 12. Was Decedent Ever in U.S. Armed Forces?
1 □ X fes 2 □ No If Yes, Give 1 9 4 3 − 4 6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3

▼ Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Tyson Foods-Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Holly Farms Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Allen Ammie Allen 2 Florence Custis Joshua Selby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheephouse Rd, Pocomoke, MD21851 Carl Selby, Jr./Son 2661 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 7-1-2010 Donation D Other (Specify) Mt. Sinia Cem Pocomoke, MD 1. Signature of Puneral Service Licenses ^{22. Name and Address of Facility} 917 W. Isabella St. Bennie Smith
Funeral Home Salisbury, MD 21801 23a. Part 1. Fiver the disease, or cimplications that caused the death. Do not enter the mode of dying, such is it right correspiratory arrangement shock, or heart failure. List only one consecutive the death. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 Yes 2 No iis certificate has been signed by the director, page 2 should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be of Vital 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Impatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🖳 Natural injury 5 Pending Division 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier 1 Certifying Physicia of e best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurs — Extending the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 127/10 pleted cause of death (mem 23a) (Type, Pri 30. Name and address of perpay, Year) State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21974 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Day} 2010 Aloysius Thomas 11:28 p.Mn George Sr. June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Mechanicsville 26156 Yowaiski Mill Road St. Mary's Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth

2 - 2 2 - 1 9 3 5 Birthplace (State or Foreign Country) **Funeral** Days Director 220-34-8973 74 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Direct ¥ ☐ Yes 2 ☐ No MD St. Mary's Mechanicsvil 10e. Street and Number 10g. Citizen of What Country? Funeral 26156 Yowaiski Mill Rd. 20659 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married CompletedDy 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: Specify:Black 3 XWidowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Private 8th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Francis Thomas Agnes Briscoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Thomas/daughter 400 Hawthorne Ct. Lusby, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Sacred Heart 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 6-30-201d Bushwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility BRISCOE-TONIC FUNERALHOME 294 Old Washington Rd Waldorf, MD20601 Part 1. Enter the dise ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final MEINSTATIC disease or condition resulting in death) PROSIATE Medical Due to (or as a consequence of): Examiner Examine physician and s the burial-trans attending physician Completed by Physician/Medical

Ph sician/

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed has page 2 After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be Medical Certificate: To

Division of Vital Records, P.O. Box 68760

if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions cor	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
25. Was case referred to medical examiner?	26. Place of Death (Che	ck only one)
1 ☐ Yes 2 ☑ No	ospital: 1	lome 5 Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Physic	cian: To the best of my knowledge, death occured at the time, date and place, a	and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

168846

HOSPITAL, 25500 POINT LOOKOUT

29d. Date sigged (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

only one) Signature and tir

AMIR

KHAN

JUN 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST. MARY'S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0607 PM **Physician** Thomas Adela 06 28 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 216 43 3063 Director 15 12-31-1994 Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD St. Mary's Chaptico Oe. Street and Number 10g. Citizen of What Country? 38005 Manor Road 20621 Funeral US death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status be filed within 72 hours after 1x Never Married 2 ☐ Married Black 1 ☐ Yes 2 → No 21215-0036 Specify 2 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 9th Student Private 17. Father's Name (First Middle Last 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland Be and Mental Louis E. Thomas Geraldine Alston ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health an Important; if item 27 is any injury or other trau Louis E. Thomas/Father Chaptico, MD 20621
Date 20c. Location - City or Town, State 38005 Manor Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart 7-7-2010 | Bushwood, MD 21. Signature of Funeral Service License 22. Name and Address of FacilityBriscoe-Tonic Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. 2294 Old Washington Rd Waldorf, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Uremia disease or condition resulting in death) /Medical Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Failure The law requires that the death certificate be executed Heart and Due to (or as a consequence of) physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 morans? 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown the 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Tetralogy of Fallot 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Rokitansky Sequence 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has 1 TYes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation or Attending (Month, Day Year) after death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Hospital 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

within 2 To the F

Michael McCror 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MO 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00067376

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6/427 2010 Day Physician/ Lillian Catherine Timmons 8:20 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Atlantic General Hospita] Worcester 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Days Hours Min. **Director** 214-32-1266 78 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be nutified at Director 28a-f 1 🗌 Yes 2 🙀 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9521 Seahawk Rd. 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married D 6/37/3010 Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: white Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Mediany injury or other traumatic event, the Medians (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 storekeeper Bav St. Market Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alfred Lewis Mattie Ouillen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Ann Dennis (daughter) 6881 Bent Pine Rd. Willards. MD 21874 000 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 6/28/2010 Frankford, 22. Name and Address of Facility TheBurbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that aused shock, or heart failure. List only one cause of such line. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical [']Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury as a consequence of that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Dav 9 Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, Vital as ca examiner? 26. Place of Death (Check only one) Hospital 2 No Other: မြ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 3 Certifying varies Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cg 29d. Date signed (Month, Day, Year) 110 30. Name and address State Registrar

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NOUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ulrich Doris Medical Examiner Facility Name (if not institution, give street and number, Town, or Location of Death 4c. County of Death ongtal odisbu icomi Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕮 F 185-25-5400 Months 07/08/1932 Pennsylvania 77 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Berlin Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 USA 12301 Snug Harbor Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛎 No Specify: white Ulrich, por 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) clothing sales clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elsie Dorwart Clyde Bender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12301 Snug Harbor Rd., Berlin, MD 21811 John Ulrich/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 6/30/2010 4 Donation 5 Other (Specify) Salisbury Crematory Salisbury, MD Signature of Funeral Service Licensee HolTowaydrumeral Home Professional Association 24 Jarrie 501 Snow Hill Rd., Salisbury, MD 21804 Mompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHAONIC Physician/ disease or condition resulting in death) ASTRUCTIVE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 4 Pregnant a Pregnant at time of death Other (specify) n signed by the a Id be detached f 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 To the Hospital or Attending Physician: The law requires 3 ☐ Probably 4 ☐ Unknown been signated by should be 1 \square Yes 2 🗌 No Completed 24a. Was an 24b. Were autopsy findings available his certificate has bil director, page 2 sh autopsy prior to completion of cause of death? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending hours after death. Accident Suicide Investigation within 24 hours after death

To the Funeral Director,

completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated cyrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Monti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10058410

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar #5, per f.h,6/30/10, e.t, Certificate of Death wchd Amended item 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. John Charles Wisniewski Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NICOMICS TENINSULA REGIONAL SALISBURY 2017 554 ty 0 182 If Under 1 Year If Under 24 H/s Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 ₹ M 2 □ F Months Hours (Month, Day, Director 04 2446 58 Usual Residence of Decedent "natural", or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2x No Worcester Bishopville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10605 St. Martins Neck Rd. 21813 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian δ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Completed 3 🗌 Widowed 4 🗆 Divorced white Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Golf Course <u>Maintenace</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wisniewski Marie Hammer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21813 Barbara Wisniewski wife 10605 St. Martins Neck Rd., Bishopville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State any injury or 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Cre 6/25/2010 Frankford, DE 4 Dopation 5 Other (Specify 21. Signature of Fineral Service 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASCVA disease or condition resulting in death) VCW Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy
Other (specify) in the past 12 months? Pregnant at time of death 2 No signed by the a d be detached f 9 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4. Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of Alcoholism 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 🗌 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 12010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 12 Caroll ST Salishy no 2184 100 E-31. Date filed (Month, Day, Year) State JUN 29 Registrar

			For State Registrar	State of M	aryland / Depa <i>Cer</i>	artment of He	ealth and			21979
			Decedent's Name (First, Middle, La	ist)		uncate of D	Catr	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia Medi	cal	Anna J 4a. Facility Name (if not institution, giv	ane	Wo	1ber		June	Day 4 2 VI	0 1:00 PM
	Exami	ner	Washington Cour	·	.1	4b. City, Town, or L Hagerst		ath	4c. County of Dea	
	Funeral	Г	5. Social Security Number 6. 5	Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year	If Under 24 H		n g Rir	thplace (State or Foreign
	Director		244-28-9414 Usual Residence of Decedent	□ M 2 🗓 F	88 Yrs.	Months Days	Hours Mi	Sept. 1	8 ^{ear)} 1921 M	aryland
	and show 1 at	ō	10a. State 10b. County		10c. City, Town or Loc	ation				10d. Inside City Limits
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	ith the 3a or t be n	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	puntry?
	eath w	nue	11.75 The Terrac	12. Was Decedent E	ver in U.S. 13. V	21742 Vas Decedent of Hisp	panic Origin?	Specify Yes or No-	U.S.A.	urican Indian
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 【【】 If Yes, Give Year or Dates.	No	√as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2X No		rto Rican, etc.)	Black, Whit	
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, Mar	d 2 shou raith and n 27 is m er traum		19a. Informant's Name/Relationship (I Gwendolyn Hatters	***		g Address (Street and			City or Town, State, Zi	
altimore, Maryland 21215-0036	Page 1 an nent of He int; If iten iry or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	20b. Place of Dispos	ation (Name of atory or other place) on Cemeter	y 6/2	Date 6/2010	20c. Location - City or	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licen		22.	Name and Address	of Facility R	est Haven	Funeral C	hapel
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	plications that caused	the death. Do not enter	the mode of dying,	such as cardia	ac or respiratory arre	st,	Approximate
_	hysician/	å ä	Immediate Cause (Final disease or condition	A Cui		nat D				Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due o (or as a	consequence of):					
	D Æ	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to or as	consequence of	Lot Carnot	<i>A</i>			
	ate be executed physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):	obstru	il, va	Lin	5 D152G	
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876	tificate ng phi as th	Med	IF FEMALE:							
P.O. Box 687	ne death certificate be executed the attending physician and ched for use as the burial-transi	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	P ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
P.0	r requires that the de been signed by the should be detached	by Pt	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the un	derlying cause given	in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	equire een si hould I	eted						1 🗌 Ye	s 2 No 3 Pr	obably 4 Unknown
Reco	The law rate has be	Sompl						24a. Was ar autops perform 1 \sum Yes 2	y prior to o ned? death?	opsy findings available completion of cause of
ta ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?				of Death (Che		12,100	2 3 10
<u> </u>	Physical this call dire	은	1 Yes 2 No		nt 2 ER/Outpatient			Home 5 Reside	nce 6 Other (Speci	fy)
o uc	nding ath. : After e funer	cate	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	Year) 28b. Time of injury	28c. Injury at work? M 1 ☐ Yes	s 2 🗆 No	28d. Describe hov	w injury occurred	
Division of Vital Records,	To the hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detach.	Certificate:	3 Suicide 6 Could not b 4 Homicide determined		y - At home, farm, stree (Specify)			28f. Location (Str. City or Town,	eet and Number or Run State)	al Route Number,
	ne Hospit in 24 hour he Funera pleted filla	Medical	(Uneck 2 L. Medical Exami	ner: On the basis of exa	ny knowledge, death oc amination and/or investig est of my knowledge, de	ation, in my opinion of	death occurred	at the time date and	I place and due to the o	auco(c) and manner stated
	Not Not To t		29b. Signature and title of certifier	wer		29c. License nu	ımber	29	dd. Date signed (Month)	Day, Year)
SH	-16		30. Name and address of person who c	munci	ath (Item 23a) (Type, Pri	nt) 1126	0	town.	MD 2171	
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar	's Signature		7 4 7	104.	3 (1)	
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andy Eugene \	Nya	and, Sr. State of Maryland / Department of H 1- For State Certificate of D Registrar		d Mental Hy	_	2010	2198
Physici		Decedent's Name (First, Middle,Last)			2. Date of Death	Day Year	3. Time of Death
ⁿ edical Exami	ner	Randy Eugene WIAND, 5K.	City Tours or	Location of Death	June 26, 20		1840 hrs
			lagerstown			Washington	
Funeral		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	lf Under 1 Yea		8. Date of Birth	(MM/DD/YYYY) 9. Birt	
Director		213-72-8246 1 <u>K</u> M 2 F 53 Yrs.	Months Day	s Hours Min.	Dec. 3		untry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	ρĮ	Pennsylvania Franklin Greencas	stle				1 Yes 2 X No
Maryland 28a-f show d at once.	Directo		Of. Zip Code		100	. Citizen of What Cour	ntry?
th the] 23a or notifie	Ö		17225			USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If Yes, s		spanic Origin? (Spe n, Mexican, Puerto F		14. Race - Ameri White, etc.	can Indian, Black,
after d	by Fu		es 2X No	specify:		Specify:	White
hours natur	edt	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's L during most of		tion (Give kind of we . DO NOT use retire		16b. Kind of Business/I	ndustry
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5-00 ed wit fygien other	Con	17. Father's Name (First, Middle, Last)		18.Mother's Name (First, Middle, Ma		
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ID 2 shoul and M 27 is m	To		•			er, City or Town, State	
e, N l and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition	n (Name of cer	metery,	Date	20c. Location - City or	Town, State
Pages tent of unt: If		1 X Burial 2 Cremation 3 Removal from State crematory or other p			2 2010	Williamsp	ort, Md.
Salti ermit. epartm nports njury o	П	21. Si pa un of Funeral Scrice Licenses 22. Name	e and Address	of Facility Mi		uneral Hom	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m	E. Wil	such as cardiac or	 Hagers respiratory arres 	t, shock, or heart	21740 Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries			, , , , , , , , , , , , , , , , , , , ,	,	Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):					
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8760, ifficate be up physical stree buri	n/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal d	Heath 3	Ectopic pregnan	icv	23d. Date of delivery Month	y Day Year
Box 6876 the death certificate the attending physic for use as the	sician/	past 12 months? 4 Pregnant at time of death 5 Other	(Specify)				
D. BC trhe de	Phy	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause o	given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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of Vital Records, ig Physician: The law require the true certificate has been sineral director, page 2 should b	Completed				24a, Was an autopsy		topsy findings available completion of cause of
Recc The lav	шо				perform 1 V Yes 2		es 2 No
tal Recian: The	Bec	25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outpatient 3		of Death (Check or			-1100
f Vi Physicer this	٩	1 Yes 2 No		Other Nursing		esidence 6 🗸 Other	Scene
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Division tal or Attendi rs after death. led in by the fi	Certification:	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa	actory, office b	ouilding, etc.	28f. Location (Str or Town, Sta		ral Route Number, City
Diversal concern I	Sel	4 Homicide determined (Specify) Major Road / Highway 29a. Certifier 1 Certifier Physician: To the best of my knowledge death secured		1	4135 Cearfoss	Pike, Hagerstown,	
Division of Vital F To the Hospital or Attending Physician: Sydthin 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation,	at the time, da in my opinion	ate and place, and o , death occurred at	due to the cause(the time, date ar	s) and manner as statend place, and due to the	ad. e cause(s)
. (/	Me	and manner stated. 29b. Signature and title of certifier	29c. License	e number	T	29d. Date signed (Mo	nth, Day, Year)
20		Meure Me Shell	O.C.I	M.E.		June 27, 2010	
5		Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner	Street P	altimore, MD 2	1201		
St	ate	31. Date filed (Month. Day Year) 32. Requestrar's Signature	- Jueel, Di	and HOTE, MID 2			
Regist		JUN 28 2010 June 1. par	the same				
DHMH 17 Rev 1/20	001	ORIGINAL					CAAF

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16:55 pm Month **Physician** Llewellyn Walker WHITTINGTON June 25, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8508 Neck Road Williamsport Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 705-10-6619 Months Days Hours 1 M 2 □ F 99 Yrs 10, Director Aug. 1910 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b County 10c. City, Town or Location ad other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10d. Inside City Limits Director Maryland Washington 1 ☐ Yes 2X No Williamsport 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 8508 Neck Road 21795 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u></u> Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other than any Injury or other trainment. maintenance worker furniture company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewellyn Laython Whittington Nellie Elizabeth Burke ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. Whittington - son 18021 Putter Drive, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cametery, crematory or other place)
Cedar Lawn Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atheroscler 031 YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 🗆 No 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1 ☐ Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Man or of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 □ No Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0056783 completed cause of death (Item 23a) (Type, Print) Jeffrey Hurwitz 10 Medical Campus Road, Hagerstown, Maryland 31. Date filed (Month State egistrar's Signatu JUN 28 Registrar

	7	, ,	- FOr	Department of Health and Certificate of Death		ene2010 21982
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic		Laura	Young	June 2	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	th	4c. County of Death
et."			5761 Irish Creek Rd.	Royal Oak	la a company	Talbot
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bird	thday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Country)
	Director		038-12-1359 1 NS STATE 83	113.	1-22-1	Rhode Island
	land ow		10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
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	r 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	h with	<u>=</u>	5761 Irish Creek Rd.	21662		USA
	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Exeminar must be netfied at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
٥	or ite		1 Never Married 2 Married 1 Yes 2 No	1 □Yes 2√2 No Specify:	,	Specify: White
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γ	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of wo life, DO NOT use retired)	orking	6b. Kind of Business/Industry
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3	2 should be and Menta Is marked aumatic ev	-	19a. Informant's Name/Relationship (Type. Print) 19b	. Mailing Address (Street and Number or R	Rural Route Number,	City or Town, State, Zip Code)
Z Z	and 2 ealth s n 27 ls		Stephan Brennan son 2	925 Main St. Edge	ewater,	Md. 21037
e e	of He of Herm		20a. Method of Disposition 20b. Place of cemeter	f Disposition (Name of ry, crematory or other place)	Date 2	0c. Location - City or Town, State
ащто	Pages nent of ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sali:	sbury Crem. 6-2	6-2010 S	alisbury, Md
a	permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 Is marke any injury or other traumatic once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hurley & Ostro	wski Fun	eral Home P.A
<u> </u>	90 = 29		23a. Part 1. Efter the disease, or complications that caused the death. Do a care to care the death of the care to care the death.	P.O. Box 518 S	t. Micha	els, Md 21663
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardia	ac or respiratory arre	st, Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death) Du to (or as a consequence	of):		Several
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	ding l	ioi	1 ☑Natural 5 ☐ Pending (Month, Day, Year)	Time of 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe ho	w injury occurred
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UNISION	lor A after Direction by	Certification: To	4 Homicide determined building, etc. (Specify)	ini, anda, idaa, j, anda	City or Town	, State)
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	To the vithing of the country of the	ž	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Month, Day, Year)
			Mizabet Schiling Cf	W/ K0824?	34	6-25-10
	TIS			(Type, Print)	CALE	Stevensville MD 2166
	10		ELIZABETH SCHILLING CAP	115 Jallitt Ix	· ource	Studionile MO 200
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	h harles		
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			For State Registrar	State of Maryland		irtment of F tificate of L			giene Reg. No. 0	0	21983
Phy	rsicia	n/	1. Decedent's Name (First, Middle, Last					2. Date of Dea	ıth	Year	3. Time of Death
N	/ledic	al	4a. Facility Name (if not institution, give s	treet and number		4h City Town o	r Location of Death	Month 07	14 20		2:34 PM
EX	amm	er	Mercy Ho-sitas	. dot and named y		Balti		\	4c. County of		
Fun Dire	eral		5. Social Security Number 6. Sec	7. Age (In yrs. last	<i>birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 12 - 23		9. Birthpl Count	lace (State or Foreign (Y) Mary Lund
			Usual Residence of Decedent	/\				1/2-23	- 19.0 = 1		
aryland a-f she	fied at	Director	Marsland 110b. County	10c. City, T	a A	(10	od. Inside City Limits 1
the Ma	e noti	Dir	10e. Street and Number	La.	- (+/v	10f. Zip Code			10g. Citizen of W	hat Count	
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	ic ever	To Be	17. Father's Name (First, Middle, Last)	11/0			18. Mother's Nam	e (First, Middle, 1	Sordo	-	
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e, N and 2 a Health em 27	ther tr		Motalie Word -1 20a. Method of Disposition	Daughter	917	awn H	ill food		over F	<u> </u>	733/
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Baltimore, permit. Page 1 and Department of Hea	y injur		21. Sign: ur of Funeral Service License		Z10 n	Name and Address	as of Facility	17 2010	· PA	V. DV.Z	1
	ं व	()	220 Part 1 Enter the disease or complete	estions that assured the death.		-70 FV	< 1/2/1/A	19 FES	13011	8 1/ /	NO 21229
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ian: The state of the state of	cior, pa		25. Was case referred to medical examiner?			26. Pla	ace of Death (Check	1 Yes	2 X No 1	Yes 2	2 LJ No
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DIVISION OT all or Attending Pt s after death. all Director: After the death of the timeral or all	n for	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office		28f. Location (St City or Town	reet and Number n, State)	or Rural F	Route Number,
Spital hours a neral D			29a. Certifier Certifying Physic	ian: To the best of my knowledg	e, death oc	cured at the time,	date and place, an	d due to the cau	se(s) and manner	as stated	
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5 ± ≤ 5	3		29b. Signature and title of certifier	. 0		29c. License			9d. Date signed		
	,	ļ	30, Name and address of person who con	npleted cause of death (Item 23a	a) (Type, Pri	nt)	301510		الماء	2010	
10 V	St-		St. Date filed (Month, Day, Year) -	32. Re strar's Signature	u B	at himore	mo				
	State istra	r	31. Date filed (Month, Day Year) 152	110 Kenera	8. 4	race					

	For	State of Maryland / Department of Health and
_	State Registrar	Certificate of Death

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Physiciar
/Medica
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinet must be redified at once.

Baltimore, Maryland 21215-0036 Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registrar

•	1 - State Registrar					Cer	rtificat	e of L	Death			Re	g. No	0.				
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er	4a. Facility Name (I						4b. City,	Town, or	Location o	of Death			40	c. County	of Death	1		
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	5. Social Security N		6. Sex		e (In yrs. las		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Mont	of Birth	Year.	3	9. Birth	place (Si	tate or I	Foreign
	219-86-2		E LIVI ZI		37	Yrs.					June	24,	137.		reu.y.	ICH IA		
	Usual Residence of 10a, State	Decedent 10b. County	,		10c City	Town or Lo	cation									10d. Insi	de City	Limits
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ne	11. Marital Status			s Decedent ned Forces?		13. \	Nas Dece	dent of Hi	spanic Ori	igin? (Sp	ecify Yes	or No-			ce - Amer		an,	
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ဒ	12 17. Father's Name	/First Middle				101.				er'e Nam	e (First, M	iddle N	1aide	n Surnai	me)			
	Williar			, Jr.					Mary	y Lo	uise	T. 7	Ni]	lson	,			
0	19a. Informant's N	ame/Relations	ship (Type, Pri	int)		19b. Mailin	ng Address	S (Street a	and Numb	er or Rui	ral Route N	Number,	City	or Town	, State, Z	ip Code)		
	William I	E. Ande	erson,	Jrfa	ather	1412	Baldi	n Mi	11 Ro	oad-i	Jarre	tts	vi]	lle,	Maryl	and	210	84
	20a. Method of Dis	position			20b. Pla	ce of Dispo	sition (Na	me of	2)		Date				- City or T			
	Mal Burial 2 4 ☐ Donation			al from State	Gard	ce of Dispo metery, cren ens O meter	f Fai	th	, i	7-1	7-10		Ros	seda.	le,Ma	aryla	and	
	21. Signatore of Fu			-							1 and		om	atio	n Sor	ozi ce	20	
	A second		1 M3	Ford	a-	_ 3	ans 1 Newoo	runer ort D	rive	-For	est H	iill	, Ma	aryl	and 2	21050	5	
	23a. Part 1. Enter t	he disease, o	r complications	s that caused	d the death.						or respirat	tory arre	est,			Appro	ximate al Betw	non.
	shock, or hea Immediate Cause	art failure. Lis	t only one caus	se on each li	ne.												and De	
	disease or condition resulting in death)	on		vere			c Br	aın	тил	игу		-		2	6			
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×a	that initiated events resulting in death)	Last	c	Due to (or as	a conseque	nce of):						10	a de					
Medical Examiner			Ld								all and	. Re	35					
edic			u								de	N. S. C.						
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CIA	in the past 12	months?	4 [Live birth Pregnant a			☐ Ectopic ☐ Other (s		·					N	lonth	Day	Ye	ar
Jysi	9 Unknown		9[Unknown														
y F	Part II. Other signi									I.	23e.	Did tol	acco	use cor	ntribute to	the caus	se of de	ath?
Ω Ω	Multipl	e rib	fract	tures	, lef	t pn	eumo	otho:	rax			1 🗆 Ye	s	2 X No	3□ Pr	obably	4 🔲 Uı	nknown
Be Completed by Physician/	Right r	adial	fract	ture,	disl	Locat	ed n	nand	ible	:	24a.	. Was a		24b	. Were au			
Ĕ	112320		-									autops perforr	ned?		death?	completio		use of
5	25. Was case refer	red to medica							OS Disc	o of Doo	th (Chack		2) 2 X IV	40	1 Ll Yes	2 X N	10	
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<u> </u>	27. Manner of Dear		288	a. Date of Inju	ury 2	28b. Time of		28c. Injur Work		uraniy H	28d. Des		w ini	urv occu	ırred			
ğ	1 ☐ Natural	5 Pendi	ng igation 7 /	(Month, Da 111/2		3:09		Work		No	otor	~ 337.0		riv 7+r	er o	oI imr	na ci	-
ES	3 ☐ Suicide	6 ☐ Could deterr	not be	e. Place of In	jury - At hom	ne, farm, str	-	y, office		111	29f 000	tion (C	root	and Nun	abor or Ri	ural Route	e Numb	
ė	4 Homicide	ueterr	Time G	building, et	tc. (Specity)					N.	city lelsc	or fowl	n, Sta 1	are) Rt	16. 1 Ja	5 at	Fta	vjl1
Medical Certification: 10	29a. Certifier	1√z Certifvi	ing Physician: I Examiner: O		dway of my know	ledge, deat	h occurre	d at the tir	ne, date a									
Ö	(Check only one)		I Examiner: O	n the basis on and manner st	of examination	on and/or in	vestigatio	n, in my o	pinion, de	ath occu	irred at the	time, d	late a	and place	e, and due	to the c	adae(s)	2100
Ze	29b. Signature and	title of certific	er				29	c. Licens	e number						ned (Mont		'ear)	
			2	- m	D		1	0054	1			יד	ul:	y 1.	3, 2	010		
	30. Name and add	ress of marcon	who complete	ed cause of a	death (Item 1	23a) (Type	Print)						_					
	Dr Bil	ae D	Kalv	on 22				- R	al+i	mor	ے M	14 2	11	201				
9	31. Date filed (Mor	nth, Day, Year	мату	32. Regist	rar's Signatu	re ire	16 D	15	идсь	TOIL	C 11	.u 2	, 1 4	<u></u>				
r	31. Date filed (Mor	JUL	152016	12	igera)	1	base	2										
			WIN	1000	4.7	1 1 M	State Bay											

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State

		-	For Amend Item 3 State Registrar	ate of Maryland,	0991 Cer	72615866 tificate of De	ealth and N eath	/lental Hy	giene Reg. N	010	21985
Phys	siciar	1/	Decedent's Name (First, Middle, Last)				2. Date of Death Month July 10, 2010 3. Time of Death 11:36p M				
M	ledica amine	al	Patrick Brinson 4a. Facility Name (if not institution, give street and number)			4b. City, Town, or L	ocation of Death	July		2010 ounty of Death	
EXE	4111111E	er .	664 Holly Circle			Aberde				rford	
Fund			5. Social Security Number 6. Sex	7. Age (In yrs. last b			If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h	g. Birth	nplace (State or Foreign ntry)
Direc			Usual Residence of Decedent	58	Yrs.			(Month, Da Sept.	15,1	951_N	ew York
/land f shov	at	io	10a. State 10b. County	10c. City, To							10d. Inside City Limits
e Man	notifie	ire	Maryland Harford	Abe	rdee	n 10f. Zip Code			10011	n of What Cou	1 🗆 Yes 2 ื No
with th	st be	Funeral Director	664 Holly Circle			21001			U.S		ин су т
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show	Jer m		11. Marital Status	/as Decedent Ever in U.S. rmed Forces?	13. V	/as Decedent of Hisp Yes, specify Cuban,	panic Origin? (Sp. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White	
after al", or	xamir	d b	1 Never Married 2 Married 1			☐ Yes 2X No		,	Spi	ecify: Bla	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o	dical	Completed	15. Decedent's Educatio	on 1	6a. Deced	ent's Usual Occupat	ion	ias		of Business In	
hin 72 ne. than "	e Wed	E O		ollege (1-4 or 5+)	life. Do	ind of work done du NOT use retired)			П	~ ~ ~ ~ 	ation
d Z ed with Hygien other i	art,	as l	12 17. Father's Name (First, Middle, Last)		<u> Pruc</u>	k Drive	C 18. Mother's Nam			sporta	ation
		To I	Harpie Brinson				Carrie			,	
should and Me	or other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of					Rural Route Number, City or Town, State, Zip Code) 29432			
and 2 Health Hem 27	ther th		Sarah Brinson/Wii			Dorange Sition (Name of		ranchv		Sout or Tition - City or T	h Carolina
Page 1	y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	uni from Ctoto Ceme	terv. cren	nation (Name of latory or other place) Hillcem) <u>i</u>			•	•
Baltimore, permit. Page 1 and 3 Department of Healt Important: If item 2	v injur	1	21. Signature of Funeral Service Licensee	HICK							Chapel, P.A
	a a		michael ! margale	<u></u>	60	09Harfo	rd Road	,Balti	more		land21214
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	se on each line.					_		Approximate Interval Between
Physician/ Medical			Immediate Cause (Final disease or condition resulting in death) Anotastatic Non-Small Cell Lung Cancer 8 months The final disease or condition resulting in death)							8 mentus	
Exami	_			Due to (or as a consequence	e oi).			7			
T .		ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	is oilji							
DIVISION Of VITAI RECORDS, P.O. BOX 68/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		Examine	Cause (Disease or iinjury that initiated events resulting in death) Last	e of):							
bU te be ex hysician	onria	dical	d d								
58/6 ertificate iding phy	as ille	Med	IF FEMALE:								
uth cert	asn Jo	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death						23d. Date of delivery Month Day Year		
he death of the atter	cued	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								
that th	e dela	by P	236. Did tobaccouse contribute to the cause of								
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n: The	or, pag								2 🗌 No		
VITAI ysician: is certific	direction	To Be	25. Was case referred to medical examiner? 1							fy)	
ng Ph	Tiera i		27. Manner of Death 1 Natural 5 Pending		o. Time of injury	28c. Injury a work?	at	28d. Describe h			
VISION or Attendii tter death. Director: At	ine I	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M 1 ☐ Yes 2 ☐ No			8f. Location (Street and Number or Rural Route Number,		
al or A after Direct Direct Links			4 Homicide determined building, etc. (Specify		ome, farm, street, factory, office 28f				City or Town, State)		
lospita 1 hours 1 hours		Medical	29a. Certifier (Chek 2 Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
the Fither 24	in pier		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
5 .≥ b 8	ಕ		Signature and the or out the	m.D.)		i4th	
6			M.D. D45390 July 14th 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myo Min (M.D.) 602 South Atwood Road # 200, Sel Air, MD 21014								
	State	е	31. Date filed (Month, Day, Year)	32. Registrar's Signature				1			````````
Reg	jistra	r	JUL 152010 A		1 105 13						

	•	For State of Maryland	-	artment of H			giene Reg. N2 0 1 0	21986	
Physicia	ın/	1. Decedent's Name (First, Middle, Last) JOHN BUTVER			-	2. Date of Dea Month	th Vear	3. Time of Death	
Medic Examin		4a. Facility Name (if not institution, give street and number) 633			Location of Death	-	4c County of Dea	h	
Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. las 83	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 1 (Month, Day 1 / 23 / 2	9. Bir (Year) Co 2 7 M	thplace (State or Foreign untry) D	
rland f show d at	tor		Town or Loc					10d. Inside City Limits	
he Mary or 28a-i	Direc	10e. Street and Number		10f. Zip Code 2120			10g. Citizen of What Co	1 ☐ Yes 2 🖾 No puntry?	
th with t ms 23a must b	Funeral Director	4108 Colby Rd	Lion			- 16 - 16 - 16 - 16 - 16 - 16 - 16 - 16	USA		
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☒ No If Yes, Give Year or Dates.	1	Nas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🛣 No	Specify:	ecity Yes or No- Rican, etc.)	Specify:	can Amer	
id 21215-0036 led within 72 hours affer Hygiene. other than "natural", o	To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 8 College (1-4 or 5+)	(Give I life, D	dent's Usual Occupa kind of work done of O NOT use retired) Sant. Er	luring most of work	ing	Balt. Ci		
		17. Father's Name (First, Middle, Last) John Bulter, Sr.			18. Mother's Nam		Maiden Surname)		
		19a. Informant's Name/Relationship (Type, Print) Gail Triplin/Daughter					; City or Town, State, Zi		
Baltimore, I oermit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other:		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ce of Dispo netery, cren VIEW	sition (Name of natory or other plac Cremato	ory 7/17	Date 7 / 1 0	20c. Location - City or Balt., MD	Town, State	
Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	5	Name and Addres	ss of Facility Har air Rd, F	Si P. C	Close F.S ID 21206-	vs.pA 5105	
Pnysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition							
Medical Examiner	_	resulting in death) Due to (or as a conseque	etix			yenres			
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	UV			YEMAS			
te be executed hysician and he burial-transit	dical Ex	resulting in death) Last Due to (or as a conseque	ence of):					4 Ems	
68/6 i ertificate iding phy se as the		IF FEMALE: 23c. If yes, outcome of pregnant	CV						
he death ce the attency the attence the for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	Day Year	
dS, P.O. quires that then signed by and be detacted.	by	Part II. Other significant conditions contributing to death but not result	ting in the u	inderly ing cause giv	ren in Part I.		bacco use contribute to	the cause of death?	
VItal Records, ysician: The law requires is certificate has been sig director, page 2 should b	Completed	Januarie Cont D				24a. Was a autop perfor 1 Yes	sy prior to death?	topsy findings available completion of cause of	
/ital /sician: s certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	B/Outpatier	Otho	ace of Death (Check		ence 6 Other (Spec	ify ALF	
nding Phy Ith. After this funeral of			8b. Time of injury	28c. Injury work	at at		ow injury occurred		
DIVISION OF tal or Attending PI rs after death. al Director: After the ed in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	eet, factory, office		28f. Location (Si City or Town	treet and Number or Run, State)	ral Route Number,	
Division of Vital Records, P.O. Box 68/6 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Vertifying Physician: To the best of my knowler 2 Medical Examiner: On the basis of examination and Certifying Nurse Practioner: To the best of my knowler (Check only one) 3 Certifying Nurse Practioner: To the best of my knowler (Check only one) 3 Certifying Nurse Practioner: To the best of my knowler (Check only one) 4 Certifying Nurse Practioner: To the best of my knowler (Check only one) 5 Certifying Physician: To the best of my knowler (Check only one) 6 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check only one) 7 Certifying Physician: To the best of my knowler (Check one) 7 Certifying Physician: To the best of my knowler (Check one) 7 Certifying Physici	and/or invest	tigation, in my opinio	n, death occurred a	t the time, date ar	nd place, and due to the	cause(s) and manner stated.	
		29b. Signature and the of certifier Alelps do M		29c. License	_	:	29d. Date signed (Mont	h, Day, Year)	
3		30. Name and address of person who completed cause of death (Item 2)	(Type, P	1-6171	82 M	_	MS Z	4090	
Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year)	re Enlas		=322				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar 21987 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Banks Virginia 07 2010 8:37a. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1700 Edmondson Ave 220 Apt Baltimore 7. Age (In yrs. last birthday) Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Days Hours Min (Month, Day, Year) Director 218-28-3878 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore 1 XYes 2 No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 U.S.A. 1700 Edmondson Ave Apt 220 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes X No Specify: If Yes Give Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Balto City Schools <u>2th grade</u> Housekeeping na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Otis Maye <u>Thomas Maye</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stout Run Ct., Catonsville, Md 21228 Constance Berry-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 7/17/2010 Parkville, Md Donation 5 Other (Specify) Parkwood Sigr of Funeral Service Licenses March F/H west 4300 Wabash Ave, Baltimore, 21215 23a. Part I. Enter he disease, or complications that sho x or hear feilure. List only one cause on each line. Immediate Cause (The disease or condition) the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Be Completed by Physician/Medical IF FEMALE: es, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year 4 ☐ Pregnant : 9 ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 ➡No 3 ☐ Probably 4 ☐ Unknown been si should l 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed' certificate 1 ☐ Yes 2 ☐ No Yes 2 W/No 25. Was case referred to medical examiner? Division of Vital director, 26. Place of Death (Check only one) Hospital: Other: 2 NO ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner 🗲 Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred After iniury 1 Natural 5 Pending s after dea.
al Director, Ar 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifi r Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho
To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Ched only one 29b. Signatu 29d. Date signed (Month, Day, Year) 0059014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Box 68760

P.O.

00

32. Registr

WASHINGTON

Baltimore, Maryland 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If Item 27 is marked other than " permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

show

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Physician /Medical Examiner certificate be executed Division or Vital Records, Physician: To the Hospital or Attend within 24 hours after death To the Funeral Director: /

> State Registrar

DHMH 17 Rev 1/2001

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

29d. Date signed (Month, Day, Year)

Baltimy

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 tem 20b per fh 9905 7-15-10 yt State of Maryland / Department of Health and Mental Hygien 20 10 21989 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year JULY 12:14 P M onne 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Memori Itimore NIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Ye 9. Birthplace (State or Foreign Country) Trinidad Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🖫 F -70-8040 72 Yrs. Director Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Nes 2 No ĮΥ H More 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, specify Cuban Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic and injury or other process. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Kosewood 0 Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) Battimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place D16 1 Surial 2 Cremation 3 Removal from State MI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and I-transit that the death certificate be executed Due to (of as a consequence of) attending physician a for use as the bunal-Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No cate has been signed by the page 2 should be detached 1 ☐ Yes ∠ ☐ g ☐ Unknown q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) completed filled in by the funeral director, Hospital Other: မ 11 Yes 2 🗌 No 1 Npatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AT2438946 ASHA SASIHANGALAM, MD JULY 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD · UNIV PKWY SASIMANGALAM, Register's Signal 31. Date jed (Monti 5020 State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

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Box

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jul v Physician/ 2010 10:10 PM Verna T. Bocek Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 6510 North Point Road Edgemere 8. Date of Birth (Month, Pay, Year) June 14, 1928 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🗓 F Months Hours Country) Director 82 214-26-1017 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21219 United States 6510½ North Point Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event" once. (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Secrectarial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Kolodziei Rose Noman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgemere, Maryland 21219 Mr. Michael A. Bocek – Husband 6510½ North Point Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 7/13/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Inc. 21222 23a. Fart 1. Enter the dispuse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine that the death certificate be executed and the burial-tran that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) be detached 9 Unknown P.O. I ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier ian 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blud

Registrar

State

31. Date filed (Month Park) Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Day Pates Iven. C. 80-30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore- Washington Medical Center Glen Burnie Anne Arundel Co. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral Months Days Min (Month, Day, Year, 1 🗆 M 2 🕡 F Hours Director 217-30-5209 11 Maryland 1935 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10b. County of Health and Mental Hygiene. item 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director Md. Anne Arundel Co. 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27 Nann Avenue U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City 12 <u>Crossing Guard</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic ew ೨ Knell John Marv Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 McDonald Rd. <u> Jennifer Pippin (granddaughter)</u> Glen Burnie, Md. 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, Md. 4 Donation 5 Other (Specify) <u>Bayview Crematory</u> 7/12/10 22. Name and Address of Facility Gonce Funeral Service P.A. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4001 Ritchie Hgwy Baltimore, Md. 21225 23a. Part 1. Enter the disease, Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Myociwalia Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown temphysema Completed s been signated the 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? Yes 2 No death? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D 39660 Senert Duct 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Dart 90 MI 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year RICIA UMME 842 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 255 Mallard Drive Pasadena Anne Arundel Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 🗆 M 2 🗷 F Months Days Hours Min. May 10, 1947 Director Mar Vland 216-48-9685 63 Usual Residence of Decedent or 28a-f show aţ 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location Director 10d. Inside City Limits must be notified 1 🗆 Yes 2 🗓 No Delaware Sussex Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 200 East Grove Street 19940 U.S.A. "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced If Yes, Give Year or Dates Specify: White Completed any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A <u>Beautician</u> Beauty Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Calvin Norwood Doris Wissman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Rodger Brummett (Husband) 200 East Grove Street Delmar, Delaware 19940 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Atlantic Cremation 07/16/2010 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ 0 disease or condition resulting in death) ELL Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of): it any teach get in redicause. Enter Underlying Cause (Disease or iinjury use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? for Pregnant at time of death Day Year been signed by the a should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မှ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of HOME 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Date signed (Month, Day, Year) 21438 70/0 Name and address of p on who completed cause of death (Item 23a) (Type, Rrint) MO21401 445 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 2010 Justine Ann Bradford 11:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 786 Nabbs Creek Road Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 M 2 TXF Months Hours Jan. 06 1952 220-56-0601 58 Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 786 Nabbs Creek Road 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 ☐ Yes 2 🔀 No Specify: Completed Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Owens Eva Mae Pigott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aimee Coffey 786 Nabbs Creek, Glen Burnie, MD 21060 (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July Date 12 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ointestinal Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as a consequence of) MOnic Hospital or Attending Physician: The law requires that the death certificate be executed 22 physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 Dunknown s been signed by the same should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was a. autopsy performed? 24a Was an s certificate has b lirector, page 2 sl 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Sesidence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Escritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one nd title of certifier 29b. Signaturea 29c. License number 29d. Date signed (Month, Day, Year,

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Re

31. Date filed (Month, Day, Year)

10-05231 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mildred Brooks State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Examiner 2038 hrs July 12, 2010 4a. Facility Name (if not institution, give street 4b. City, Town, or Location of Death 4c. County of Deat 2410 Huron Street **Baltimore** If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Funeral Days Months Hours Min. Director 215-03-5056 Usual Residence of Decedent 1 M Yrs 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 23a or 28a-f show notified at once, permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examingr must be notified at once. irector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Yes 3 Widowed 1 Yes 2 No specify: 4 Divorced f Yes. Give Year \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Lity or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery or Town, State crematory or other place) 1 Burial 2 Cremation 3 4 Donation 5 Other Specify 21. Signalure of Fundrul Service Licensee 22. Name and Address of Facility 23a Part I. Enterune disease, or complications that caused the death. Do not enter the glode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician ajlurg. List only one cause on each line. Between Onset and /Medical Death Staphylococcus Aureus Sepsis Examiner or condition resulting in death) Due to (or as a consequence of): Vesiculobullous Skin Disease Sequentially list conditions, Examiner If any, leading to immediate Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical AMENDED 23a,b,pt.II,27 per me g918 8-10-11 vt the attending physician led for use as the burial -X UNPENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown as been signed by t should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Atherosclerotic Cardiovascular Disease Completed Records, certificate has been 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed death? ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene DOA this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Director: d in by the f Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: 2 Accident Investigation filled in by 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide Homicide 29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. July 13, 2010

Registrar

OCME 2006

State

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Russell Alexander MD.

31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Thomas Malcolm Bilson July 2010 :07 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carrol County Dove Center Westminster Carrol1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth

July 3, 1945 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Sex 14 M 2 □ F Days Director 214-44-3377 65 Usual Residence of Decedent f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f 1 ☐ Yes 2X No Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23a Funeral 1276 Pinch Valley Road 21158 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. should be filed within 72 hours after of and Mental Hygiene. "natural", or Completed by 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Plumber HVAC Mechanical Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Francis Daniel Bilson Margaret Eloise Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Mr Thomas C. Bilson/ Son 612 California Terrace Gambrills MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State JulyDale6. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Vets. Cem. 2010 Crownsville, MD 21. Signature Funeral Pervice Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 10,220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease of illigary that initiated events Exami Box 68760 Ley ysician and e burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical phys: attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 No 1 🗌 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) PATIES 1 Tes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 I 27. Manne eath Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospita to reconstitution 24 hours after death.

To the Funeral Director: After a the Funeral Director of the Funeral Director and the fur Natural 5 Pending ☐ Accident 1 Yes Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Ourtifying Nurse Fractional To the best of my knowledge, de dist the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) FO

Registrar DHMH 17 Rev 7/2009

State

HavioKrute MD

152010

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

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Records,

Division of Vital

Casto

Sheet 1

ted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#20a-b, perFH, G905, 7/28/2010, WS
State of Maryland / Department of Health and Mental Hygiena

Items 10e, 19b per in, g905, 07/19/2010dnb

Certificate of Death

Reg. No. 0 | 0 Amend Items 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 10:55AM medi 2010 /Medical a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Yrs. Director 217-19-8659 69 August 26,1940 Philippines Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Md. Balto. Rosedale 10e. Street and Number 8843 Trimble Way 10f. Zip-Code 10q. Citizen of What Country? or items 23a or Trimble Funeral 21237 **IISA** Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 2 3 Widowed 4 Divorced Specify: Asian "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than LPN Hospita1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental H Arturo Francia 2 Adela Aricheta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 | 9843 Trimble Way Ernesto L. Centeno Spouse Rosedale, Md. 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Bayview Crematory or other play 1 The state of th 4 ☐ Donation 5 ☐ Other (Specify) 7-15-2010 Balto.Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. le 9705 Belair Road Nottingham, Md. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** metasatic vancveatic.

Due to (or as a consequence di): disease or condition /Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a nonsequence or): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 | Yes 2 No 9 | Unknown Pregnant at time of death 5 Other (specify) be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2 No 2 🗌 No this certificate 25. Was case referred to medical director. Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 \sum Nursing Home 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending P after death. Director: After to Certification: 1 Natural
2 Accident 5 Pending investigation Injury 1 Yes 2 🗆 No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Hospita Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DØØ7Ø511 aux 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V 600 North Wolfe St, Baltimore, MD, 21287 auren 32. Regis ar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 0 Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 12, Day 2010 Year Physician/ $\mathtt{Ju}^{\mathtt{Month}}_{\mathbf{y}}$ 2155 Callis Bernice Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Center Medical Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Pay Year) 12. 27, 1933 1 □ M 2 🛣 F Days Hours Min. North Carolina **Director** 216-30-5799 76 Usual Residence of Decedent , or items 23a or 28a-f show 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie MD Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 U.S.A. 1005 Upton Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?_ 14. Bace - American Indian. Completed by 2 X No 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 Yes X No Specify: If Yes, Give Specify: American Indian 3 Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Super Market 8 Cashier To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richardson permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Randolph Sylver 01a Edgar traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rita Griffith/Daughter <u> 2800 Superior Ave. Baltimore, MD 21234</u> 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State July 17, Glen Burnie, Maryland Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 1 2nd Ave. SW Glen Burnie, MD MO1580 Singleton Funeral & Cremation Services PA 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Phrumonia disease or condition day Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjuly that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, c Abrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Chinknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N certificate ha death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ္ 1/X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation within 24 hours after death

To the Funeral Director: A Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69566 10

Registrar DHMH 17 Rev 7/2009

State

5 2010

2001 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parkway

32. Registrar's Signatu

Annapolis,

21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CRAYTON 17. 45 PM KEVIN 2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Town, or Location of Death **Examiner** UMM ALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 XM 2 □ F 7. Age (In vrs. last birthday) **Funeral** Days Min (Month, Day, Year) Country) NY Oldo. 60. 145= Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County Director Randallstown 1 ☐ Yes 2 XNo MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral IIIsemere 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Investment Banker 12thavade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name #First, Middle, Last) ပ္ Mae Francis Thomas Avthur Lee Crayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1750 Eagle Trace Boulevard Oval Springs FL 33071 Roxanne Crayton Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Date Baltimore, MD 09/2010 Greenmount Crematory DT 4 ☐ Donation 5 ☐ Other (Specify) iv Vaugno C. Greene Funeral services Road Randallotown MD 21133 22. Name and Address of acility 21. Signature of Funeral Service Licensee iberty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death subarachnoin Immediate Cause Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last the burial-transit Due to (or as a consequence of) nding physician use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ rate has been signed by the atte page 2 should be detached for i in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 L 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown ivision of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) fo the Hospital or Attending Physician: Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🕭 No 1 Donatient 2 ER/Outpatient 3 DOA ပ္ this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 L 3 L only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title, 19800 2010 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ML

Registrar DHMH 17 Rev 7/2009

State

South

GREENE

27

32. Registrar's Signature

MD

MIKLOSH BALA 31. Date filed (Month, Day, Year)

152010

10-05030 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Stephanie Cherry State of Maryland / Department of Health and Mental Hygiene 2010 21999 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** Month D July 5, 2010 Stephanie Cherry

4a. Facility Name (if not institution, give street and number) 0727 hrs 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number **Funeral** If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Hours | Min. | 12 Foreign 7. Age (In yrs. last birthday) If Under 1 Year Director 212 80 1409 Months 43 1 M 2 X F ,1966 July Country) MD Usual Residence of Deceden iny 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits s 23a or 28a-f show s e notified at once, MD n/a Baltimore filed within 72 hours after death with the Maryland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5106 Frankford Ave. 21206 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Noor items 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X No Yes Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner 4 Divorced Yes, Give Year Yes 2 X No specify: ş Specify:Black or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7. 10th Nursing Assistant Nursing Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) George Cherry Jr. Barbara Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifton Bowens (son) 1107 N. Darley Ave. Balto, Md. 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Sta crematory or other place) portant: Oak Lawn Cem. uly 20,2010 Balto,Md. 4 Donation 5 Other Specify: Swature of Funeral Service Licensee ²² Name and Address of Facility Callvin B. Scruggs Funeral Home Part I. Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shoc 21213 Balto Md Physician Approximate Interva failure. List only one cause on each line /Medical Between Onset and CArdiac arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of Myocardial hypertrophy Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): se. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical AMENDED #8perFH,G905,7/15/10,WS UNPENDED per ME g905 7/29/10 TT attending physician or use as the burial The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month past 12 months? Day Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions Ö contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, P.

page 2 should has certificate

UNISION Of Vital Revision of Vital Revision of Attending Physician: The within 24 hours after death.

Completed 25. Was case referred to medical funeral director. æ examiner? Hospital: 1 Inpatient 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification 1 X Natural e Funeral Director: / Pending 2 Accident Investigation 3 Could not be determined Homicide

ignature and title of certifie

5 2010

OCME

State

Medical

29b

1 Yes 2 V No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performe death? ✓ Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other 2 V ER/Outpatient 3 □ DOA 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

O.C.M.E

29c. License number

29d. Date signed (Month, Day, Year) July 6, 2010

Death

30. Name and address of person who completed cause of death (Item 23a)

Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

State of Maryland / Department of Health and Mental Hygien 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1106 PM Tuly 2010 Michael Henry Doring /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMUKE BALTIMORE If Under 1 Year If Under 24 Hrs. HUSP AUNES SAMUT LTAZ Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Sex 1 M 2 □ F Days Hours 1949 Maryland 217-50-7670 March 6. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be putfled as once. 1 ☐ Yes 2 ☑ No Director Anne Arundel Co. Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 600 Dover Rd. U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 □Yes 2 ☑No Specify: 3 ☐ Widowed 4 ☑ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Labor Relations Elementary/Secondary (0-12) College (1-4or 5+) Laborer Information Serv. Self employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry W. Doring Mary Juanita Rawson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Md. 21146 20c. Location - City or Town, State Liza Nicole Griffith (daughter) 319 Carlyn Dr. Severna Park, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Md. Veterans Cemetery 7/15/10 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Hgwy. Balto. Md. 21225 runustust erane 23a. P. 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DMS Physician CARDIAC ARREST disease or condition resulting in death) /Medical 4 DRS Examiner End stage REMAL DISTRICT Sequentially list conditions, if any, leading to miniculate cause. Enter Underlying Cause (Disease or injury that initiated events PERIPARAL VASCULAR DISEASE the attending physician and hed for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 ∐Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Denpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 D Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7/10/10 1130 pm mo P 23575 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CuAm 32. Registrar's Signature BATTIMORE, MD MARIA C. ESCAM State Registrar

3altimore, Maryland 21215-0036

P.O. Box 68760.

Records.

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